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JOURNAL

BEHAVIORAL AND MENTAL HEALTHCARE: TOTAL WARRIOR CARE COMMITMENT

July - September 2008

THE UNITED STATES ARMY MEDICAL DEPARTMENT

A Professional Publication of the AMEDD Community

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Perspective

Major General Russell J. Czerw

From the beginning of the recorded history of campaigns and combat between organized armies, wars and battles were usually characterized in terms of glory and pride, focused on the noble leaders and the outcomes. Soldiers were the heroes returning from some distant and unknown place, with only the stories they told to family and friends portraying the grim reality of the actual events. Lip service was given to the sacrifice of the Soldiers, but the public's interest in the details of conflicts were short-lived or nonexistent. Usually only the outcomes framed in terms of the glory and righteousness of the effort remained in anyone's memory, except those of the combatants. The Soldiers were expected to return from the campaigns and simply resume their normal lives, without regard to their experiences—or their memories. After all, to those who were not there, combat was a glamorous enterprise, surrounded by flags, banners, drummers, and flashy uniforms.

There is no better example of the naiveté of the public about the stark realities of the battlefield than that demonstrated in July 1861 by the wealthy elite of Washington, DC, including some members of Congress. After the Army of Northeastern Virginia left the capital with great fanfare to engage nearby Confederate forces, news of the impending battle at Bull Run near Manassas, Virginia, quickly spread around the capital. The prospect of witnessing such a glamorous undertaking became a fashionable event. As the battle began, the hillsides and meadows behind Union lines were populated with fancy carriages as families socialized and spread their picnic meals to relax and enjoy the spectacle. Unfortunately, the grim facts of warfare quickly interrupted their holiday, as the Union Army was routed and they were engulfed in the tide of fleeing Soldiers, severely complicating the retreat in their panic.[1]

The Civil War has been described as the first conflict of modern warfare. Advances in technology in weapons, communications, and transportation combined with a higher level of sophistication in strategy and tactics to make the Civil War the most lethal conflict to that point in history. Technology also allowed Mathew Brady to document the war as photographic images, something that had never occurred before. Of course, stiffly posed pictures of military leaders and Soldiers had been published, but Brady took his cameras into the battlefield. He photographed the carnage and devastation he found there. In September 1862, Brady was present at the Battle of Antietam, which included the bloodiest single day in American military history. His exhibits of the pictures of the dead of that battle were a shocking revelation to the public. For the first time, they could see the experiences of the men who left them to go to war. However, perhaps more importantly, for the first time the public at large had a sense of how warfare affected those who fought, and returned. In presenting the reality of warfare, Brady's photographs challenged the popular notions that combat and death on the battlefield were noble, glorious undertakings. During this extended, horrific war, the medical sciences began to recognize a psychological disorder, called battle fatigue (BF), as a direct result of the experiences of the battlefield. Indeed, one of the most respected physicians of his time, Dr Oliver Wendell Holmes,

who himself had gone to the Antietam battlefield to locate his wounded son, commented on Brady's photographs:

> Let him who wishes to know what the war is look at this series of illustrations. These wrecks of manhood thrown together in careless heaps or ranged in ghastly rows for burial were but alive yesterday.... Many people would not look through this series. Many, having seen it and dreamed of its horrors, would lock it up in some secret drawer.[2]

As profound as Holmes' comments are, they were directed at the reactions of those who viewed the photographs. The "secret drawer" of the combat veteran contains memories of not only the sights of battlefield carnage, but also the sounds, smells, tastes, and pain of the experience.

Fifty years later, greater leaps in technology and tactics produced carnage at an even greater scale in the First World War. Fortunately, increased knowledge and sophistication in mental health care allowed military medicine to recognize and address the psychological toll of such horrific environments:

> When the German Army initially introduced 'gas' warfare, psychiatric to WIA ratios in Allied ground forces often exceeded 2:1; ie, two 'hysterical' reactions occurred for every one casualty due to actual gas exposures. The large number of BF casualties produced and the inability to evacuate and replace these Soldiers prompted the Allies to develop basic principles of effective treatment: treat as far forward as possible, treat as quickly as possible, and treat with the expectation that the Soldier will recover and return to combat.[3]

The learning process continued through World War II, Korea, Vietnam, and Operation Desert Storm, and continues today in the Global War on Terror. The RAND Center for Military Health Policy Research has recently released a detailed report[4] from a comprehensive study of the mental and psychological health of Warriors returning from combat deployments to Iraq and Afghanistan. The RAND report reinforces the increasing emphasis that military medicine is placing on the behavioral and mental health of our Warriors, reflected in the Army Medical Department's increased application of resources, changes in structure, and aggressive, proactive actions addressing prevention, intervention, therapy, and recovery. Those aspects of our efforts to address the behavioral and mental health needs of our Warriors are featured in this dedicated issue of the *AMEDD Journal.*

We are pleased to open this issue with a reprint of an article from the *New England Journal of Medicine* which presents what has become the de facto baseline study of the mental health situation among Warriors engaged in combat operations in Afghanistan and Iraq. In 2003, COL Charles Hoge and his team of experienced researchers evaluated the mental health conditions of ground combat troops both before and after deployment into the combat theaters. Their rigid scientific method, large sample sizes, and detailed, careful data reduction and analysis have provided invaluable information for those charged with the mental health care of our Warriors, both during and after their experiences in the fluid and unpredictable combat environments of today. Indeed, this article has often been referenced in other writings on these topics. COL Hoge et al set the stage for the articles that follow in this very important issue of the *AMEDD Journal.*

We are fortunate to have 4 articles in this issue which were written by authors providing behavioral and mental healthcare to our Warriors on the ground in Iraq. The first article in this collection is by CPT Patrick Pischke and CPT Christian Hallman. Their excellent article describes their experiences with critical event debriefing, a technique developed to deal with psychological trauma, not only by the military in a combat environment, but also used for police, firefighters, rescue personnel, emergency room staff, and others who experience traumatic events. Research and experience in past extended conflicts solidly support the proposition that mental health service provided as quickly as possible after a traumatic event is critical to prevention of the onset of posttraumatic stress and other anxiety disorders. Research also shows that such disorders can become chronic and more resistant to treatment with the passage of time. The article details the research, and describes the results of 38 group critical event debriefings administered in Iraq between March 2004 and January 2005. The data gathered by CPT Pischke and CPT Hallman strongly validate the presence of mental healthcare resources among front line forces, and the application of assistance to those experiencing traumatic events as quickly as possible.

CPT Brian Parrish has contributed an intriguing, very informative article about the innovative adaptation of a treatment regimen designed for those with borderline personality disorder to assist Soldiers in the combat environment. The intense emotions which are driven by the never-ending pressures of life and death decisions in a constant crisis environment can cause some Soldiers to exhibit some of the same psychological liabilities as those with classic personality disorders. CPT Parrish's article describes the use of dialectical behavior therapy as an intervention tool, designed to keep the Soldier functioning within the duty environment while dealing with the issues that threaten their psychological well-being. Therapy is available 24 hours a day at a specific location, a wellness center located within the troop medical facility which mitigates the stigma Soldiers often feel about seeking mental health assistance. This creative approach to ensuring our Warriors have assistance where and when needed is another demonstration of the high level of initiative and professionalism that is fundamental to military medicine.

As important as intervention and therapy are to those Soldiers who experience psychological problems in the combat environment, those actions represent one aspect of mental healthcare—treatment. Mental healthcare also has a preventive care responsibility. MAJ Thomas Jarrett's article is a detailed, carefully organized discussion of the development and implementation of Warrior-oriented combat stress prevention training to be presented in-theater. This Warrior Resilience Training is designed to strengthen our Soldiers' psychological resistance to the deleterious effects of traumatic events. The approach to this type of training contains much reinforcement in the ethics, values, and standards that are reflected in Army Ethos and Army Values, as well as the various codes of conduct and rules that are part of professional military discipline and character. MAJ Jarrett details the foundations of the Warrior Resilience Training, how it is integrated into the deployment training cycle, and the overwhelmingly positive feedback received from those who receive it in-theater.

Obviously, the remoteness and stark reality of the combat deployment environment introduces types of stress and pressures unseen in a normal garrison situation, therefore mandating the provision of far greater range of behavioral and mental healthcare services than those required for the typical garrison clinical setting. The previous 3 articles reflect the diversity and extent of some of those services. However, the activity workload metrics used in a "normal" environment are not designed to track much of the workload of behavioral and mental health personnel on these deployments. Without such data, the requirements experienced in that real world cannot be quantified. Planners and developers for organizations, structure, doctrine, and training, just to name a few, are unable to address the needs for ongoing support, much less look to future requirements. Also, and perhaps more important, commanders cannot be provided with real-time data about the services used by their Soldiers. To the properly educated leader, such data is invaluable information about the psychological readiness of his or her Soldiers to perform the required missions. The leader can then take necessary measures to address problem areas revealed in the statistics. In his very informative article, MAJ Barron Hung describes the Combat and Operational Stress Control Workload and Activity Reporting System (COSC-WARS), which was implemented at the beginning of Operation Iraqi Freedom in response to the need for such data. MAJ Hung presents and discusses COSC-WARS data for the 6-month period January to June 2008, as an example of the type of information that is obtained, and the implications that the results have for the individual Soldiers and their units. This article is a succinct and valuable validation of the methods and support services discussed in the 3 preceding articles, as well as a revealing look at the extent and diversity of the factors causing tension and stress among our Warriors.

Of the several destructive behaviors that may result from psychological anxieties induced by the combat environment or other high stress situations, none is more pernicious than acts of violence, including murder, against enemy prisoners, noncombatants, or even other US service members. Although extremely rare, these incidents do happen in our military. The occurrence of such acts is not only tragic for the victim and the perpetrator, but it may also have serious ramifications for the success of the mission, and for the military in general. LTC Karen Marrs has written an important article which presents the research, theories, and facts surrounding illegal violence by

military members. Her article details a concept for an addition to the current combat and operational stress control actions to deal directly with a Soldier's state of mind, usually involving revenge and frustration, which, if unchecked, can lead to illegal violence. The potential for such incidents may be greater than we think, as LTC Marrs points out that the DoD Mental Health Advisory Team V's report[5] (2007) found a troubling attitude of disdain and disrespect for local national noncombatants among a majority of deployed Soldiers and Marines. As expertly explained in the article, without a baseline of respect for such individuals, the overwhelming combination of rage, frustration, and revenge has no check, often with tragic results. LTC Marrs presents the Remind concept as a proactive effort to give Warriors a psychological tool to deal with the environment, the circumstances, and especially the emotions encountered in the current deployed environments. This is a thoughtful, informative article about a very serious subject which warrants the close attention of military leaders and mental health professionals.

Those professionals providing behavioral and mental healthcare services to Warriors and their Families are the front lines of assistance for those in need. They are also the leading edge of an extensive structure of planners, researchers, training specialists, and other support staff who make it possible for them to apply their skills, training, and dedication to their work. The remaining articles in this issue of the *AMEDD Journal* present information on the leadership and training provided within the behavioral health disciplines of the Army Medical Department. Leading off this section, COL Elspeth Ritchie, the first Director of the Behavioral Health Proponency of the Office of The Surgeon General, has contributed an article describing the establishment of the Proponency in March 2007. She discusses the background of her position, and outlines the initiatives that have addressed areas of concern within behavioral healthcare, both existing and future. The Proponency provides a badly needed focal point at the highest levels of Army medicine for an increasingly important aspect of Soldier healthcare.

The largest obstacle in the provision of behavioral or mental healthcare services is the unwillingness of those needing assistance to avail themselves of the service. That unwillingness may stem from failure to recognize the need (or rejection of the idea), but quite often it is present due to the stigma associated with mental healthcare. For this reason, it is important for military healthcare providers (ie, primary care, allied healthcare provider) to be equipped with the tools to recognize and manage mental health disorders. In their article, Karen Shea and Dr Maryann Pechacek describe the importance of the properly trained healthcare provider in the actual delivery of psychological health therapy to many patients who would otherwise avoid or reject it. Their interesting article details the circumstances that make such an arrangement ideal for many patients. Military healthcare providers are currently taught the information and skills necessary for the effective management of mental health disorders within the military healthcare setting at the AMEDD Center & School (AMEDDC&S).

The Mental Health Advisory Team V[5] reported that 15.5% of Soldiers and Marines surveyed in Afghanistan and Iraq (2007) screened positive for acute stress/posttraumatic stress disorder (PTSD). The previously mentioned RAND study's findings[4] support that statistic, indicating that 14% of service members returning from Iraq met the criteria for PTSD. Obviously, this disorder represents a significant challenge for military behavioral healthcare professionals, both in-theater and at home garrison medical treatment facilities. Dr Gerard Grace's article presents the clinical background, evolution, and implementation of a PTSD treatment training program at the AMEDDC&S. This important article clearly details the challenges and complexities faced by those charged with developing the most effective approach to training our behavioral health professionals to recognize and treat PTSD, now and into the future.

Just as the Warrior Resilience Training discussed by MAJ Jarrett in his article is designed to enable Soldiers on the line to resist the deleterious psychological effects of traumatic combat events, so must we be concerned with the psychological fitness of the caregivers who must deal with the aftermath of combat, the wounded Soldiers and noncombatants. During periods of heavy combat operations, the stream of severely wounded people can be nonstop, and the wounds are often horrific and extensive. This circumstance places extreme pressure and stress on the medical professionals who labor to save those lives, sometimes continuously for many hours without relief. In their well-written article, Dr Richard Boone and his

coauthors describe the Army Provider Resiliency Training (PRT) Program, developed and implemented to address the psychological health of those dedicated to saving and improving the lives of others. Although the PRT Program has been a formal part of Army medical training only since July 2008, the need was recognized in 2001. Since then, various approaches to providing healthcare professionals the necessary knowledge and tools have been used, all part of the evolution to the current PRT Program, which will be mandatory training for all AMEDD caregivers. This program is one of the Army's answers to the perpetual question, "who takes care of the caregivers?"

Throughout history, humans have used mood altering substances for various purposes, some beneficial, some detrimental. The concern for society in general is, of course, the detrimental abuse of such substances. The damage to the abuser is profound, but the danger to others who are not involved in that person's self-destructive activity is even more tragic. In the situation of a military, especially combat, environment, interdependence among all members of a unit is a daily, life and death reality. An individual whose psychological, and physical, capabilities are impaired by the effects of alcohol and/or drugs represents a truly serious liability to the safety of the other members of the unit. Further, a substance abuser may also be a direct physical threat to other Soldiers, and/or to him or herself. Joseph Hallam has contributed an important article describing the current situation among our Soldiers in Iraq, and the AMEDDC&S training resources which are addressing those problems. There are currently 6 formal courses providing training to military Mental Health Specialists, Healthcare Specialists, civilian counselors, clinical directors and supervisors, and physicians. The increased availability of counseling services, both in-theater and at home installations, provides healthcare providers, commanders, and other leaders with additional resources to assist our Warriors and their Families with this extremely difficult personal and societal problem.

Another of the undesirable consequences of the psychological pressures, stresses, and disorders that affect Soldiers in a combat environment is the negative impact they can have on the Warrior's Family relationships. Dissolutions of marriages and family breakups following return from deployment are far too common. At the extreme, we see the reports of physical abuse, including the death of one or both spouses, and sometimes children. The family advocacy approach to address the stresses of military life on the family was developed in the 1980s. Cindi Geeslin and her coauthors describe the evolution of the AMEDD Family Advocacy Staff Training Course which debuted in 1985 to prepare Family Advocacy Program staff members to implement the program throughout the Army. Their article lays out how the course is designed, and how it has changed over the years in adaptation to DoD requirements and in response to the latest research in the areas of family dynamics and violence. As the family advocacy approach has matured, new requirements and methods of training have been identified. In addition to the 2-week basic course, AMEDDC&S now presents 6 advanced courses to address the specific training needs of the professional staff. Also, a distance learning component of the basic course is nearing completion. Not only will the distance learning element reduce the resident training requirement to one week with attendant savings in time and money, but it also allows expansion of content in the course, a clear benefit to the Soldiers and their Families who need help. The energy, professionalism, and commitment of resources described in this article clearly show the commitment of the Army to the "whole" Soldier, which includes the Family as full partners in service to our country.

The previous 5 articles have dealt with the AMEDDC&S training directed at those charged with providing mental and behavioral health evaluation, treatment, and counseling. A recently created (March 2007) organization within AMEDDC&S, the Battlemind Training Office (BTO) has the mission to develop and deliver evolving, sophisticated, and multifaceted psychological resiliency training packages aimed at the Warriors themselves. In their article, MAJ (Ret) John Orsinger and his coauthors chronicle the establishment of the BTO to address the need for an organizational approach to the mental preparation of Soldiers to successfully deploy and then transition back to their home lives. The Battlemind concept is an extremely important "big picture" approach, not focused exclusively on that period a Soldier spends in the combat theater. Rather, when fully instituted, Battlemind training will encompass the entire cycle that prepares a Soldier for deployment, the deployment itself, and the "decompression" that is necessary as a Warrior leaves the combat environment

and undergoes the psychological transition to the safety and security of normal life. Both pre- and postdeployment training include blocks with the Warriors and their Families together to ensure all parties are prepared for those changes that are unavoidable, for both the Warrior and Family. Understandably, the development of such an expansive, yet integrated concept into the numerous training packages necessary is a major undertaking. The Battlemind Training Office has become the largest entity in the Soldier and Family Support Branch of the AMEDDC&S. Its mission is recognized throughout the AMEDD and Army senior command levels as critical to combat readiness and effectiveness, Soldier and Family satisfaction, and, of course, retention of that invaluable resource, our professional Warriors.

Dr Dexter Freeman and MAJ Graeme Bicknell close this issue of the *AMEDD Journal* with an article presenting a exciting new professional education opportunity within the AMEDD. The AMEDD has teamed with Fayetteville State University to establish a Master of Social Work degree granting program for military members which is presented at the AMEDDC&S. The program, which started its initial class in June 2008, addresses a complicated problem which has plagued Army Social Work since its establishment in 1943. Until now, it was necessary for the Army to source graduates of civilian institutions for all of its military social workers. Of course, those new Soldiers, although well educated in the knowledge and skills of the civilian social work environment, had no exposure to the markedly different environment of the military. Since 1945, AMEDD has presented a subprofessional training program to orient new social workers, but the adjustment period on the job is long, and effectiveness of services is sometimes adversely affected as the new Army social worker becomes accustomed to the unfamiliar world in which he or she must practice their skills. A further complication arose in 1998 when federal law mandated that military social workers must possess a professional license to practice. This requirement extended the period between graduation and eligibility to enter the Army and practice by over 2 years, further shrinking the pool of potential candidates as their interest in the military waned during their exposure to private practice. The Army-Fayetteville State University Master of Social Work program is designed to source students from within the military—thus eliminating the need for adjustment and reorientation—and provide a graduate education from an accredited institution tailored to our environment. The graduate then completes the supervised practice-examination-licensure phase at a military facility, providing the Army with a much needed resource who is more effective from day one than those entering the military directly from civilian education and practice. The professionals within the AMEDDC&S have worked long and hard on this innovative, desperately needed initiative that will help ensure Soldiers and Families receive the best possible support services and care. They are to be congratulated on their success.

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Combat Duty in Iraq and Afghanistan, Mental Health Problems and Barriers to Care

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ABSTRACT

BACKGROUND

The current combat operations in Iraq and Afghanistan have involved US military personnel in major ground combat and hazardous security duty. Studies are needed to systematically assess the mental health of members of the armed services who have participated in these operations and to inform policy with regard to the optimal delivery of mental health care to returning veterans.

METHODS

We studied members of 4 US combat infantry units (3 Army units and a Marine Corps unit) using an anonymous survey that was administered to the subjects either before their deployment to Iraq (n=2530) or 3 to 4 months after their return from combat duty in Iraq or Afghanistan (n=3671). The outcomes included major depression, generalized anxiety, and posttraumatic stress disorder (PTSD), which were evaluated on the basis of standardized, self-administered screening instruments.

RESULTS

Exposure to combat was significantly greater among those who were deployed to Iraq than among those deployed to Afghanistan. The percentage of study subjects whose responses met the screening criteria for major depression, generalized anxiety, or PTSD was significantly higher after duty in Iraq (15.6% to 17.1%) than after duty in Afghanistan (11.2%) or before deployment to Iraq (9.3%); the largest difference was in the rate of PTSD. Of those whose responses were positive for a mental disorder, only 23% to 40% sought mental health care. Those whose responses were positive for a mental disorder were twice as likely as those whose responses were negative to report concern about possible stigmatization and other barriers to seeking mental health care.

CONCLUSIONS

This study provides an initial look at the mental health of members of the Army and the Marine Corps who were involved in combat operations in Iraq and Afghanistan. Our findings indicate that among the study groups there was a significant risk of mental health problems and that the subjects reported important barriers to receiving mental health services, particularly the perception of stigma among those most in need of such care.

The recent military operations in Iraq and Afghanistan, which have involved the first sustained ground combat undertaken by the United States since the war in Vietnam, raise important questions about the effect of the experience on the mental health of members of the military services who have been deployed there. Research conducted after other military conflicts has shown that deployment stressors and exposure to combat result in considerable risks of mental health prob-

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lems, including posttraumatic stress disorder, major depression, substance abuse, impairment in social functioning and in the ability to work, and the increased use of healthcare services.[1-8] One study that was conducted just before the military operations in Iraq and Afghanistan began found that at least 6% of all US military service members on active duty receive treatment for a mental disorder each year.[9] Given the ongoing military operations in Iraq and Afghanistan, mental disorders are likely to remain an important healthcare concern among those serving there.

Many gaps exist in the understanding of the full psychosocial effect of combat. The all-volunteer force deployed to Iraq and Afghanistan and the type of warfare conducted in these regions are very different from those involved in past wars, differences that highlight the need for studies of members of the armed services who are involved in the current operations. Most studies that have examined the effects of combat on mental health were conducted among veterans years after their military service had ended.[1-8] A problem in the methods of such studies is the long recall period after exposure to combat.[10] Very few studies have examined a broad range of mental health outcomes near to the time of subjects' deployment.

Little of the existing research is useful in guiding policy with regard to how best to promote access to and the delivery of mental health care to members of the armed services. Although screening for mental health problems is now routine both before and after deployment[11] and is encouraged in primary care settings,[12] we are not aware of any studies that have assessed the use of mental health care, the perceived need for such care, and the perceived barriers to treatment among members of the military services before or after combat deployment.

We studied the prevalence of mental health problems among members of the US armed services who were recruited from comparable combat units before or after their deployment to Iraq or Afghanistan. We identified the proportion of service members with mental health concerns who were not receiving care and the barriers they perceived to accessing and receiving such care.

METHODS

Study Groups

We summarized data from the first, cross-sectional phase of a longitudinal study of the effect of combat on the mental health of the Soldiers and Marines deployed in Operation Iraqi Freedom and in Operation Enduring Freedom in Afghanistan. Three comparable US Army units were studied with the use of an anonymous survey administered either before deployment to Iraq or after their return from Iraq or Afghanistan. Although no data from before deployment were available for the Marines in the study, data were collected from a Marine Corps unit after its return from Iraq that provided a basis for comparison with data obtained from Army Soldiers after their return from Iraq.

The study groups included 2530 Soldiers from an Army infantry brigade of the 82nd Airborne Division, whose responses to the survey were obtained in January 2003, one week before a year-long deployment to Iraq; 1962 Soldiers from an Army infantry brigade of the 82nd Airborne Division, whose responses were obtained in March 2003, after the Soldiers' return from a 6-month deployment to Afghanistan; 894 Soldiers from an Army infantry brigade of the 3rd Infantry Division, whose responses were obtained in December 2003, after their return from an 8-month deployment to Iraq; and 815 Marines from 2 battalions under the command of the 1st Marine Expeditionary Force, whose responses were obtained in October or November 2003, after a 6-month deployment to Iraq. The 3rd Infantry Division and the Marine battalions had spearheaded early ground-combat operations in Iraq, in March through May 2003. All the units whose members responded to the survey were also involved in hazardous security duties. The questionnaires administered to Soldiers and Marines after deployment to Iraq or Afghanistan were administered 3 to 4 months after their return to the United States. This interval allowed time in which the Soldiers completed leave, made the transition back to garrison work duties, and had the opportunity to seek medical or mental health treatment, if needed.

Recruitment and Representativeness of the Sample

Unit leaders assembled the Soldiers and Marines near their workplaces at convenient times, and the study investigators then gave a short recruitment briefing and obtained written informed consent on forms that

included statements about the purpose of the survey, the voluntary nature of participation, and the methods used to ensure participants' anonymity. Overall, 58% of the Soldiers and Marines from the selected units were available to attend the recruitment briefings (79% of the Soldiers before deployment, 58% of the Soldiers after deployment in Operation Enduring Freedom in Afghanistan, 34% of the Soldiers after deployment in Operation Iraqi Freedom, and 65% of the Marines after deployment in Operation Iraqi Freedom). Most of those who did not attend the briefings were not available because of their rigorous work and training schedules (eg, night training and post security).

A response was defined as completion of any part of the survey. The response rate among the Soldiers and Marines who were briefed was 98% for the 4 samples combined. The rates of missing values for individual items in the survey were generally less than 15%; 2% of participants did not complete the PTSD measures, 5% did not complete the depression and anxiety measures, and 7% to 8% did not complete the items related to the use of alcohol. The high response rate was probably owing to the anonymous nature of the survey and to the fact that participants were given time by their units to complete the 45-minute survey. The study was conducted under a protocol approved by the institutional review board of the Walter Reed Army Institute of Research.

To assess whether or not our sample was representative, we compared the demographic characteristics of respondents with those of all active-duty Army and Marine personnel deployed to Operation Iraqi Freedom and Operation Enduring Freedom, using the Defense Medical Surveillance System.[13]

SURVEY AND MENTAL HEALTH OUTCOMES

The study outcomes were focused on current symptoms (ie, those occurring in the past month) of a major depressive disorder, a generalized anxiety disorder, and PTSD. We used 2 case definitions for each disorder, a broad screening definition that followed current psychiatric diagnostic criteria[14] but did not include criteria for functional impairment or for severity, and a strict (conservative) screening definition that required a self-report of substantial functional impairment or a large number of symptoms. Major depression and generalized anxiety were measured with the use of the patient health questionnaire developed by Spitzer et al.[15-17] For the strict definition to be met, there also had to be evidence of impairment in work, at home, or in interpersonal functioning that was categorized as at the "very difficult" level as measured by the patient health questionnaire. The generalized anxiety measure was modified slightly to avoid redundancy; items that pertained to concentration, fatigue, and sleep disturbance were drawn from the depression measure.

The presence or absence of PTSD was evaluated with the use of the 17-item National Center for PTSD Checklist of the Department of Veterans Affairs.[4,8,18,19] Symptoms were related to any stressful experience (in the wording of the "specific stressor" version of the checklist), so that the outcome would be independent of predictors (ie, before or after deployment). Results were scored as positive if subjects reported at least one intrusion symptom, 3 avoidance symptoms, and 2 hyperarousal symptoms[14] that were categorized as at the moderate level, according to the PTSD checklist. For the strict definition to be met, the total score also had to be at least 50 on a scale of 17 to 85 (with a higher number indicating a greater number of symptoms or greater severity), which is a well-established cutoff.[4,8,18,19] Misuse of alcohol was measured with the use of a 2-question screening instrument.[20]

In addition to these measures, on the survey participants were asked whether they were currently experiencing stress, emotional problems, problems related to the use of alcohol, or family problems and, if so, whether the level of these problems was mild, moderate, or severe; the participants were then asked whether they were interested in receiving help for these problems. Subjects were also asked about their use of professional mental health services in the past month or the past year and about perceived barriers to mental health treatment, particularly stigmatization as a result of receiving such treatment.[21] Combat experiences were modified from previous scales.[22]

QUALITY-CONTROL PROCEDURES AND ANALYSIS

Responses to the survey were scanned with the use of ScanTools software (Pearson NCS). Quality control procedures identified scanning errors in no more than 0.38% of the fields (range, 0.01% to 0.38%). SPSS software (version 12.0) was used to conduct the analyses, including multiple logistic regression that was used to control for differences in demographic characteristics of members of study groups before and after deployment.[23,24]

Table 1. Demographic Characteristics of Study Groups of Soldiers and Marines as Compared with Reference Groups.*

Characteristic	Army Study Groups			Marine Study Group	Army Reference Group (N=61,742)	Marine Reference Group (N=20,194)
	Before Deployment to Iraq (N=2530)	After Deployment to Afghanistan (N=1962)	After Deployment to Iraq (N=894)	After Deployment to Iraq (N=815)		
Age	number (%)					
18–24 yr	1647 (66)	1226 (63)	528 (59)	652 (80)	32,840 (53)	13,824 (69)
25–29 yr	496 (20)	387 (20)	206 (23)	114 (14)	13,737 (22)	3,174 (16)
30–39 yr	336 (13)	316 (16)	147 (16)	41 (5)	12,960 (21)	2,703 (13)
40 yr or older	34 (1)	28 (1)	13 (2)	4 (1)	2,205 (4)	493 (2)
Sex						
Male	2489 (99)	1934 (99)	879 (98)	815 (100)	61,201 (99)	20,090 (99.5)
Female	26 (1)	23 (1)	14 (2)		541 (1)	104 (0.5)
Race or ethnic group						
White	1749 (70)	1339 (69)	531 (60)	544 (68)	44,365 (72)	15,344 (76)
Black	208 (8)	198 (10)	185 (21)	53 (7)	7,904 (13)	1,213 (6)
Hispanic	331 (13)	254 (13)	102 (12)	141 (18)	6,140 (10)	2,642 (13)
Other	195 (8)	141 (7)	67 (8)	63 (8)	3,262 (5)	867 (4)
Education						
High-school graduate or less	1955 (78)	1514 (78)	726 (82)	728 (89)	48561 (79)	16892 (84)
Some college or other	202 (8)	153 (8)	73 (8)	29 (4)	3260 (5)	346 (2)
College graduate	339 (14)	277 (14)	85 (10)	54 (7)	8838 (14)	2945 (15)
Military grade						
Enlisted personnel†						
E1–E4	1585 (63)	1170 (60)	613 (69)	601 (84)	33823 (55)	13744 (68)
E5–E6	614 (24)	524 (27)	228 (26)	77 (11)	14813 (24)	2850 (14)
E7–E9	116 (5)	91 (5)	23 (3)	8 (1)	3819 (6)	607 (3)
Officer	200 (8)	168 (8)	30 (3)	26 (4)	9287 (15)	2993 (15)
Marital status						
Single	1142 (50)	908 (52)	355 (46)	455 (63)	32636 (53)	12332 (61)
Married	936 (41)	685 (39)	338 (43)	204 (28)	27582 (45)	7499 (37)
Other	199 (9)	168 (9)	85 (11)	65 (9)	1485 (2)	363 (2)

*Data exclude missing values, because not all respondents answered every question. Percentages may not sum to 100 because of rounding. Data for the reference groups were obtained from the Defense Medical Surveillance System's deployment rosters of Army and Marine personnel deployed in Operation Iraqi Freedom and in Afghanistan in 2003. The total number of persons on these rosters was 315,999, of whom 229,034 (72%) were active-duty personnel; the remaining 86,965 were members of the Reserve and National Guard; 97,906 (31%) had a designation of a combat-arms occupation. Of the 229,034 active-duty service members, 81,936 (36%) had combat-arms occupations, including 61,742 Soldiers and 20,194 Marines in the reference groups.

†Higher numbers indicate higher grades.

RESULTS

The demographic characteristics of participants from the 3 Army units were similar. The Marines in the study were somewhat younger than the Soldiers in the study and less likely to be married. The demographic characteristics of all the participants in the survey samples were very similar to those of the general, deployed, active-duty infantry population, except that officers were undersampled, which resulted in slightly lower age and rank distributions (Table 1). Data for the reference populations were obtained from the Defense Medical Surveillance System with the use of available rosters of Army and Marine personnel deployed to Iraq or Afghanistan in 2003 (Table 1).

Among the 1709 Soldiers and Marines who had returned from Iraq, the reported rates of combat experiences and frequency of contact with the enemy were much higher than those reported by Soldiers who had returned from Afghanistan (Table 2). Only 31% of Soldiers deployed to Afghanistan reported having engaged in a firefight, as compared with 71% to 86% of Soldiers and Marines who had been deployed to Iraq. Among those who had been in a firefight, the median number of firefights during deployment was 2 (interquartile range, 1 to 3) among those in Afghanistan, as compared with 5 (interquartile range, 2 to 13; $P<0.001$ by analysis of variance) among Soldiers deployed to Iraq and 5 (interquartile range, 3

Table 2. Combat Experiences Reported by Members of the US Army and Marine Corps after Deployment to Iraq or Afghanistan*

Experience	Army Group		Marine Group
	Afghanistan (N=1962)	Iraq (N=894)	Iraq (N=815)
	number/total number (%)		
Being attacked or ambushed	1139/1961 (58)	789/883 (89)	764/805 (95)
Receiving incoming artillery, rocket, or mortar fire	1648/1960 (84)	753/872 (86)	740/802 (92)
Being shot at or receiving small-arms fire	1302/1962 (66)	826/886 (93)	779/805 (97)
Shooting or directing fire at the enemy	534/1961 (27)	672/879 (77)	692/800 (87)
Being responsible for the death of an enemy combatant	229/1961 (12)	414/871 (48)	511/789 (65)
Being responsible for the death of a noncombatant	17/1961 (1)	116/861 (14)	219/794 (28)
Seeing dead bodies or human remains	771/1958 (39)	832/879 (95)	759/805 (94)
Handling or uncovering human remains	229/1961 (12)	443/881 (50)	455/800 (57)
Seeing dead or seriously injured Americans	591/1961 (30)	572/882 (65)	604/803 (75)
Knowing someone seriously injured or killed	850/1962 (43)	751/878 (86)	693/797 (87)
Participating in demining operations	314/1962 (16)	329/867 (38)	270/787 (34)
Seeing ill or injured women or children whom you were unable to help	907/1961 (46)	604/878 (69)	665/805 (83)
Being wounded or injured	90/1961 (5)	119/870 (14)	75/803 (9)
Had a close call, was shot or hit, but protective gear saved you	†	67/879 (8)	77/805 (10)
Had a buddy shot or hit who was near you	†	192/880 (22)	208/797 (26)
Clearing or searching homes or buildings	1108/1961 (57)	705/884 (80)	695/805 (86)
Engaging in hand-to-hand combat	51/1961 (3)	189/876 (22)	75/800 (9)
Saved the life of a Soldier or civilian	125/1961 (6)	183/859 (21)	150/789 (19)

*Data exclude missing values, because not all respondents answered every question. Combat experiences are worded as in the survey.

†The question was not included in this survey.

to 10; P<0.001 by analysis of variance) among Marines deployed to Iraq.

Soldiers and Marines who had returned from Iraq were signifieantly more likely to report that they were currently experiencing a mental health problem, to express interest in receiving help, and to use mental health services than were Soldiers returning from Afghanistan or those surveyed before deployment (Table 3). Rates of PTSD were significantly higher after combat duty in Iraq than before deployment, with similar odds ratios for the Army and Marine samples (Table 3). Signifieant assoeiations were observed for major depression and the misuse of alcohol. Most of these associations remained significant after control for demographic factors with the use of multiple logistic regression (Table 3). When the prevalence rates for any mental disorder were adjusted to match the distribution of officers and enlisted personnel in the reference populations, the result was less than a 10% decrease (range, 3.5% to 9.4%) in the rates shown in Table 3 according to both the broad and the strict definitions (data not shown).

For all groups responding after deployment, there was a strong reported relation between combat experienees, such as being shot at, handling dead bodies, knowing someone who was killed, or killing enemy combatants, and the prevalence of PTSD. For example, among Soldiers and Marines who had been deployed to Iraq, the prevalence of PTSD (according to the strict definition) inereased in a linear manner with the number of firefights during deployment: 4.5% for no firefights, 9.3% for one to 2 firefights, 12.7% for 3 to 5 firefights, and 19.3% for more than 5 firefights (chi-square for lincar trend, 49.44; P<0.001). Rates for those who had been deployed to Afghanistan were 4.5%, 8.2%, 8.3%, and 18.9%, respectively (chi square for linear trend, 31.35; P<0.001). The percentage of participants who had been deployed to Iraq who reported being wounded or injured was 11.6% as compared with only 4.6% for those who had been deployed to Afghanistan. The rates of PTSD were signifieantly assoeiated with having been wounded or injured (odds ratio for those deployed to Iraq, 3.27; 95% confidence interval, 2.28 to 4.67; odds ratio for those deployed to Afghanistan, 2.49; 95% confidence interval, 1.35 to 4.40).

Of those whose responses met the sereening criteria for a mental disorder aeeording to the strict case definition, only 38% to 45% indicated an interest in reeeiving help, and only 23% to 40% reported having received professional help in the past year (Table 4). Those whose responses met these screening criteria were generally about 2 times as likely as those whose responses did not to report concern about being stigmatized and about other barriers to aeeessing and receiving mental health serviees (Table 5).

DISCUSSION

We investigated mental health outcomes among Soldiers and Marines who had taken part in the ground-eombat operations in Iraq and Afghanistan. Respondents to our survey who had been deployed to Iraq reported a very high level of combat experiences, with more than 90% of them reporting being shot at and a high pereentage reporting handling dead bodies, knowing someone who was injured or killed, or killing an enemy eombatant (Table 2). Close ealls, sueh as having been saved from being wounded by wearing body armor, were not infrequent. Soldiers who served in Afghanistan reported lower but still substantial rates of such experiences in combat.

The pereentage of study subjeets whose responses met the sereening criteria for major depression, PTSD, or alcohol misuse was significantly higher among Soldiers after deployment than before deployment, particularly with regard to PTSD. The linear relationship between the prevalenee of PTSD and the number of firefights in which a Soldier had been engaged was remarkably similar among Soldiers returning from Iraq and Afghanistan, suggesting that differences in the prevalence aceording to location were largely a function of the greater frequency and intensity of combat in Iraq. The association between injury and the prevalence of PTSD supports the results of previous studies.[25]

These findings can be generalized to ground combat units, which are estimated to represent about a quarter of all Army and Marine personnel participating in Operation Iraqi Freedom and Operation Enduring Freedom in Afghanistan (when members of the

Table 3. Perceived Mental Health Problems and Percentage of Subjects Who Met the Screening Criteria for Major Depression, Generalized Anxiety, Post-Traumatic Stress Disorder, and Alcohol Misuse.*

Mental Health Problem	Army Study Groups					Marine Study Group	
	Before Deployment to Iraq (N=2530)	After Deployment to Afghanistan (N=1962)		After Deployment to Iraq (N=894)		After Deployment to Iraq (N=815)	
	no./total no. (%)	no./total no. (%)	OR (95% CI)	no./total no. (%)	OR (95% CI)	no./total no. (%)	OR (95% CI)
Perceived moderate or severe problem	323/2261 (14.3)	303/1769 (17.1)†‡		153/784 (19.5)†‡		123/720 (17.1)	
Currently interested in receiving professional help	211/2243 (9.4)	180/1769 (10.2)		131/786 (16.7)†‡		106/706 (15.0)†‡	
Received professional help in the past month§	108/2280 (4.7)	118/1780 (6.6)†‡		91/796 (11.4)†‡		70/742 (9.4)†‡	
Definition of mental disorder							
Broad definition							
Depression according to PHQ	275/2418 (11.4)	267/1885 (14.2)	1.29 (1.07–1.54)†‡	128/840 (15.2)	1.40 (1.12–1.76)†‡	114/775 (14.7)	1.34 (1.06–1.70)¶
Anxiety according to PHQ	375/2419 (15.5)	324/1886 (17.2)	1.13 (0.96–1.33)	147/839 (17.5)	1.16 (0.94–1.43)	122/776 (15.7)	1.02 (0.81–1.27)
PTSD according to PCL	226/2414 (9.4)	224/1956 (11.5)	1.25 (1.03–1.52)¶	159/881 (18.0)	2.13 (1.71–2.66)†‡	161/811 (19.9)	2.40 (1.92–2.99)†‡
Any of above	522/2500 (20.9)	479/1958 (24.5)	1.23 (1.07–1.41)†‡	246/882 (27.9)	1.47 (1.23–1.75)†‡	237/813 (29.2)	1.56 (1.30–1.87)†
Strict definition							
Depression according to PHQ	128/2418 (5.3)	130/1885 (6.9)	1.33 (1.03–1.71)‡¶	66/840 (7.9)	1.53 (1.12–2.08)†‡	55/775 (7.1)	1.37 (0.99–1.90)
Anxiety according to PHQ	155/2419 (6.4)	140/1886 (7.4)	1.17 (0.92–1.48)	66/839 (7.9)	1.25 (0.92–1.68)	51/776 (6.6)	1.03 (0.74–1.43)
PTSD according to PCL	120/2414 (5.0)	121/1956 (6.2)	1.26 (0.97–1.64)	114/881 (12.9)	2.84 (2.17–3.72)†‡	99/811 (12.2)	2.66 (2.01–3.51)†‡
Any of above	233/2500 (9.3)	220/1958 (11.2)	1.23 (1.01–1.50)¶	151/882 (17.1)	2.01 (1.61–2.51)†‡	127/813 (15.6)	1.80 (1.43–2.27)†‡
Alcohol misuse							
Have you used alcohol more than you meant to?	405/2358 (17.2)	452/1844 (24.5)	1.57 (1.35–1.82)†‡	198/819 (24.2)	1.54 (1.27–1.86)†‡	268/756 (35.4)	2.65 (2.20–3.18)†‡
Have you felt you wanted or needed to cut down on your drinking?	289/2313 (12.5)	331/1821 (18.2)	1.56 (1.31–1.85)†‡	168/815 (20.6)	1.82 (1.47–2.24)†‡	219/744 (29.4)	2.92 (2.39–3.57)†‡

*Each study group who responded after deployment was compared with the group that responded before deployment, with the use of odds ratios (with 95% confidence intervals) and chi-square testing. Data exclude missing values, because not all respondents answered every question. OR denotes odds ratio, CI confidence interval, PHQ patient health questionnaire, PTSD post-traumatic stress disorder, and PCL the National Center for Post-Traumatic Stress Disorder Checklist.

†P<0.01 for the comparison of groups responding after deployment with the group responding before deployment, calculated with the use of the chi-square test.

‡The result remained significant after multiple logistic regression was used to control for age, rank, educational level, marital status, and race or ethnic group.

§Professional help was defined as help from a mental health professional, a general medical doctor, or a chaplain or other member of the clergy, in either a military or civilian treatment setting.

¶P<0.05 for the comparison of groups responding after deployment with the group responding before deployment, calculated with the use of the chi-square test.

Table 4. Perceived Need for and Use of Mental Health Services among Soldiers and Marines Whose Survey Responses Met the Screening Criteria for Major Depression, Generalized Anxiety, or Post-Traumatic Stress Disorder*

Outcome	Army Study Groups			Marine Study Group
	Before Deployment to Iraq (N=233)	After Deployment to Afghanistan (N=220)	After Deployment to Iraq (N=151)	After Deployment to Iraq (N=127)
	number/total number (%)			
Need				
Acknowledged a problem	184/215 (86)	156/192 (81)	104/133 (78)	91/106 (86)
Interested in receiving help	85/212 (40)	75/196 (38)	58/134 (43)	47/105 (45)
Received professional help†				
In past year				
Overall (from any professional)	61/222 (28)	46/198 (23)	56/140 (40)	33/113 (29)
From a mental health professional	33/222 (15)	26/198 (13)	37/138 (27)	24/112 (21)
In past month				
Overall (from any professional)	39/218 (18)	34/196 (17)	44/136 (32)	23/112 (21)
From a mental health professional	24/218 (11)	25/196 (13)	29/136 (21)	16/111 (14)

*Data exclude missing values, because not all respondents answered every question.
†Professional help was defined as help from a mental health professional, a general medical doctor, or a chaplain or other member of the clergy, in either a military or civilian treatment setting.

Reserve and the National Guard are included) and nearly 40% of all active-duty personnel (when Reservists and members of the National Guard are not included). The demographic characteristics of the subjects in our samples closely mirrored the demographic characteristics of this population. The somewhat lower proportion of officers had a minimal effect on the prevalence rates, and potential differences in demographic factors among the 4 study groups were controlled for in our analysis with the use of logistic regression.

One demonstration of the internal validity of our findings was the observation of similar prevalence rates for combat experiences and mental health outcomes among the subjects in the Army and the Marine Corps who had returned from deployment to Iraq, despite the different demographic characteristics of members of these units and their different levels of availability for recruitment into the study.

Table 5. Perceived Barriers to Seeking Mental Health Services among All Study Participants (Soldiers and Marines)*

Perceived Barrier	Respondents Who Met Screening Criteria for a Mental Disorder (N=731)	Respondents Who Did Not Meet Screening Criteria for a Mental Disorder (N=5422)
	number/total number (%)	
I don't trust mental health professionals.	241/641 (38)	813/4820 (17)
I don't know where to get help.	143/639 (22)	303/4780 (6)
I don't have adequate transportation.	117/638 (18)	279/4770 (6)
It is difficult to schedule an appointment.	288/638 (45)	789/4748 (17)
There would be difficulty getting time off work for treatment.	354/643 (55)	1061/4743 (22)
Mental health care costs too much money.	159/638 (25)	456/4736 (10)
It would be too embarrassing.	260/641 (41)	852/4752 (18)
It would harm my career.	319/640 (50)	1134/4738 (24)
Members of my unit might have less confidence in me.	377/642 (59)	1472/4763 (31)
My unit leadership might treat me differently.	403/637 (63)	1562/4744 (33)
My leaders would blame me for the problem.	328/642 (51)	928/4769 (20)
I would be seen as weak.	413/640 (65)	1486/4732 (31)
Mental health care doesn't work.	158/638 (25)	444/4748 (9)

*Data exclude missing values, because not all respondents answered every question. Respondents were asked to rate" each of the possible concerns that might affect your decision to receive mental health counseling or services if you ever had a problem." Perceived barriers are worded as on the survey. The 5 possible responses ranged from "strongly disagree" to "strongly agree," with "agree" and "strongly agree" combined as a positive response.

The cross-sectional design involving different units that was used in our study is not as strong as a longitudinal design. However, the comparability of the Army samples and the similarity in outcomes among subjects in the Army and Marine units surveyed after deployment to Iraq should generate confidence in the cross-sectional approach. Another limitation of our study is the potential selection bias resulting from the enrollment procedures, which were influenced by the practical realities that resulted from working with operational units. Although work schedules affected the availability of Soldiers to take part in the survey, the effect is not likely to have biased our results. However, the selection procedures did not permit the enrollment of persons who had been severely wounded or those who may have been removed from the units for other reasons, such as misconduct. Thus, our estimates of the prevalence of mental disorders are conservative, reflecting the prevalence among working, nondisabled combat personnel. The period immediately before a long combat deployment may not be the best time at which to measure baseline levels of distress. The magnitude of the differences between the responses before and after deployment is particularly striking, given the likelihood that the group responding before deployment was already experiencing levels of stress that were higher than normal.

The survey instruments used to screen for mental disorders in this study have been validated primarily in the settings of primary care and in clinical populations. The results therefore do not represent definitive diagnoses of persons in nonclinical populations such as our military samples. However, requiring evidence of functional impairment or a high number of symptoms, as we did, according to the strict case definitions, increases the specificity and positive predictive value of the survey measures.[26,27] This conservative approach suggested that as many as 9% of Soldiers may be at risk for mental disorders before combat deployment, and as many as 11% to 17% may be at risk for such disorders 3 to 4 months after their return from combat deployment.

Although there are few published studies of the rates of PTSD among military personnel soon after their return from combat duty, studies of veterans conducted years after their service ended have shown a prevalence of current PTSD of 15% among Vietnam veterans[28] and 2% to 10% among veterans of the first Gulf War.[4,8] Rates of PTSD among the general adult population in the United States are 3% to 4%,[26] which are not dissimilar to the baseline rate of 5% observed in the sample of Soldiers responding to the survey before deployment. Research has shown that the majority of persons in whom PTSD develops meet the criteria for the diagnosis of this disorder within the first 3 months after the traumatic event.[29] In our study, administering the surveys 3 to 4 months after the subjects had returned from deployment and at least 6 months after the heaviest combat operations was probably optimal for investigating the long-term risk of mental health problems associated with combat. We are continuing to examine this risk in repeated cross-sectional and longitudinal assessments involving the same units.

Our findings indicate that a small percentage of Soldiers and Marines whose responses met the screening criteria for a mental disorder reported that they had received help from any mental health professional, a finding that parallels the results of civilian studies.[30-32] In the military, there are unique factors that contribute to resistance to seeking such help, particularly concern about how a Soldier will be perceived by peers and by the leadership. Concern about stigma was disproportionately greatest among those most in need of help from mental health services. Soldiers and Marines whose responses were scored as positive for a mental disorder were twice as likely as those whose responses were scored as negative to show concern about being stigmatized and about other barriers to mental health care.

This finding has immediate public health implications. Efforts to address the problem of stigma and other barriers to seeking mental health care in the military should take into consideration outreach, education, and changes in the models of healthcare delivery, such as increases in the allocation of mental health services in primary care clinics and in the provision of confidential counseling by means of employee-assistance programs. Screening for major depression is becoming routine in military primary care settings,[12] but our study suggests that it should be expanded to include screening for PTSD. Many of these considerations are being addressed in new military programs.[33] Reducing the perception of stigma and the barriers to care among military personnel is a priority

for research and a priority for the policymakers, clinicians, and leaders who are involved in providing care to those who have served in the armed forces.

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Effectiveness of Critical Event Debriefings During Operation Iraqi Freedom II

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ABSTRACT

Team members of a US Army medical combat stress control unit provided critical event debriefings for military personnel who were directly involved in a traumatic event during Operation Iraqi Freedom II. Each person attending the debriefing was then given a short 5-question survey immediately following the session. Out of the 396 participants who completed the survey questionnaire, 273 felt the debriefing given by the team was helpful, 97 had no opinion, and 26 did not feel it was helpful. This particular combat stress control team was located in Taji, Iraq. The data was collected from debriefings conducted from the beginning of March 2004 to mid-January 2005.

INTRODUCTION

Perhaps nothing is more stressful than the experience of war. The very sights, sounds, and smells that one experiences in war can have an everlasting impact, physically, emotionally, and mentally. Since the outbreak of the war in Iraq, the Army has sent numerous medical units to the Middle East to help treat people suffering from both physical and psychological trauma. Specialized medical units called combat stress control (CSC) are used primarily to provide mental health related services throughout the theater of operation. Members of CSC units include a variety of mental healthcare professionals such as psychiatrists, psychologists, social workers, occupational therapists, psychiatric nurses, and mental health specialists. CSC units are mainly deployed to preserve the fighting strength of the Army by treating wounds that do not bleed. They often take a proactive approach by sending small teams around to different sites and offering a variety of classes in the prevention of battle fatigue. CSC members are also trained to provide individual counseling and can even utilize a number of different therapeutic techniques to help ease any psychological suffering.

One technique that was designed to help people heal from psychological trauma is called a critical event debriefing (CED). Most CSCs use critical event debriefings in a group setting for any personnel who were unfortunate enough to be directly involved in a traumatic event. These CEDs were often conducted by different team members of the CSC in numerous locations throughout the theater of operation. To attend a CED, one had to either be a member of the CSC team, or someone who was directly involved in some capacity with the traumatic event. No one else was permitted to attend. Chaplains were sometimes in attendance as part of the CSC team.

LITERATURE REVIEW

Recent research studies have indicated the severity and distinction of mental health affects of combat Soldiers engaged in wartime operations. It has been reported that at least 17% of postcombat veterans have depression, anxiety, or posttraumatic stress disorder (PTSD).[1] Hoge et al[2] reported in their study of combat infantry Soldiers that the percentage of study subjects whose responses met the screening criteria for major depression, generalized anxiety, or PTSD was significantly higher after duty in Iraq (15.6% to 17.1%) than after duty in Afghanistan (11.2%). A 12-member advisory team surveyed 756 Soldiers in Iraq and found that 87% of Soldiers reported high levels of stress over not knowing how long they would be deployed, 71% reported high levels of stress regarding length of deployment, 57% reported high levels of stress over separation from family, and 55% reported high levels of stress over the lack of privacy and personal space.[3]

According to the *Diagnostic and Statistical Manual of Mental Disorders*,[4] PTSD and panic disorder (PD) are classified as anxiety disorders, which are initially triggered by some kind of traumatic event that has not been treated properly. Literature addresses the importance of early mental health treatment following a traumatic event. As cited by Vesper,[5] Litz mentions that

there is evidence that once veterans develop military-related PTSD, the symptoms remain chronic across their lifetime and they become resistant to treatment that has been shown to work with other forms of chronic PTSD. One of the most commonly reported clinical problems in anxiety disorders, such as PTSD and PD, are disturbances in sleep.[6] Combat veterans with PTSD frequently report sudden awakenings from nightmares that closely resemble their most salient traumatic experience.[7] PTSD patients with comorbid PD may express additive symptoms of central fear system disturbance.[8] Thus, it is vitally important to provide early intervention to reduce chronic impairments in veterans.[5] Significant findings include the discovery that providing Soldiers with immediate psychological intervention close to the front lines increase the likelihood of their recovering sufficiently to return to duty.[9] Psychologist Viktor Razdvev studied combatants in Chechnya and indicated that he, and others, recognized that if you can get to a person in hours, or no later than 2 to 3 days after suffering psychological trauma, you could weaken or even prevent PTSD's onset.[10]

Several studies have implicated the benefits derived from providing mental health services, such as critical incident stress debriefings (CISD), to individuals who have experienced traumatic events. A debriefing can be conducted near the site of the actual event.[11,12] Another component of a CISD is a defusing. To be most helpful, debriefing and diffusing techniques must be done 24 to 72 hours after the initial impact of the event.[13,14] Eid et al[15] studied military personnel (n=9) and civilian firefighters (n=9) involved with a severe car accident in which rescue efforts placed the workers in harms way. The group that received additional psychological debriefings reported fewer PTSD symptoms.[15] Jenkins[16] researched 34 male and 2 female emergency medical technicians, paramedics, and firefighters who worked at the site of a mass shooting. Jenkins reported that 52% of the sample (n=15) attended at least one CISD while the control group choose not to participate with the CISD. It was found that participation with debriefings as correlated with lower depression and anxiety scores one month post-shooting. Shalev et al[17] studied 39 Israeli Soldiers exposed to direct combat and found the debriefing correlated with self-report reduction in anxiety symptoms and improvement in self-efficacy. Burns and Harm[18] studied emergency nurses (n=682) and found that 88% of the survey population who had participated in debriefings found them helpful. Robinson and Mitchell[19] studied 172 emergency service, welfare, and hospital personnel in Australia and found that most personnel who reported symptoms of stress following a traumatic incident stated that these symptoms had been reduced as a consequence of attending the debriefing.

Some articles and studies address the barriers experienced by military personnel to receive mental health services. To treat combat stress effectively, the primary barrier that the US Army must overcome is the fear of stigmatization that Soldiers associate with mental health treatment.[20] Friedman[21] mentions that those returning from Operation Iraqi Freedom or Operation Enduring Freedom who reported the greatest number or most severe symptoms were the least likely to seek treatment for fear that it could harm their careers, cause difficulties with their peers and within unit leadership, and become an embarrassment in that they would be seen as weak. Hoge et al[2] reported in their study of US combat infantry Soldiers and Marines in Iraq and Afghanistan that those whose responses were positive for a mental health disorder, only 23% to 40% sought mental health care. It has been determined that at least 60% of veterans are unlikely to seek mental health help secondary to the fear of stigma or loss of career advancement opportunities.[1]

METHODOLOGY

This study involved a sample of convenience (n=396) of US military personnel who attended a CED following a traumatic event. The CED technique used in this study is based upon the 7-stage CISD Mitchell Model.[22] Data was collected from 38 separate CEDs administered from the beginning of March 2004 through mid January 2005 during Operation Iraqi Freedom II. The different groups that participated in the CEDs ranged in size from 2 to 24 participants. Each participant experienced a traumatic war event in Iraq which involved death, serious injury, and/or life threatening circumstances. The location of the study was the Forward Operating Base, Camp Cooke, Taji, Iraq.

The data collection instrument was a 5 item (Likert scale) self-survey form as illustrated in Figure 1. Participants were given instructions for completion of the survey after the CED. Survey forms were completed confidentially and concise identification features were excluded from each survey form to achieve the atomicity of each participant. Participation with the study was voluntary, although strongly encouraged, and there was a 100% participation rate.

CRITICAL EVENT DEBRIEFING SURVEY

Today's Date:	Date of Event:	Gender:	Age:	Rank:

1. Do you feel the critical event you experienced will have a long-term negative impact on your activities of daily living? (Circle one that best applies)

1	2	3	4	5
Strongly Disagree	Disagree	No Opinion	Agree	Agree Strongly

2. Do you feel this CED was helpful?

1	2	3	4	5
Strongly Disagree	Disagree	No Opinion	Agree	Agree Strongly

3. Do you think the CED would have been most helpful if conducted within 2 hours of the critical incident?

1	2	3	4	5
Strongly Disagree	Disagree	No Opinion	Agree	Agree Strongly

4. After the CED, do you think a follow up appointment is important?

1	2	3	4	5
Strongly Disagree	Disagree	No Opinion	Agree	Agree Strongly

5. Have you had difficulty talking with others about the critical incident?

1	2	3	4	5
Strongly Disagree	Disagree	No Opinion	Agree	Agree Strongly

We appreciate your feedback. Feel free to write comments on back.

Figure 1. The self-survey form used to collect data to evaluate the effectiveness of critical event debriefings following traumatic combat events in and around Taji, Iraq (March 2004 - January 2005).

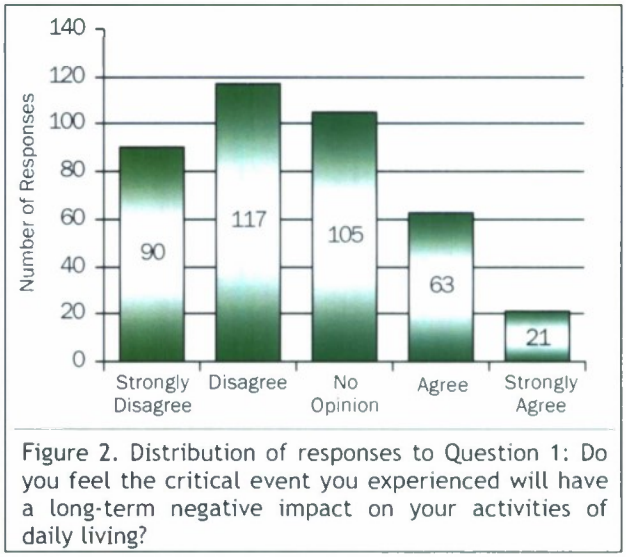

Figure 2. Distribution of responses to Question 1: Do you feel the critical event you experienced will have a long-term negative impact on your activities of daily living?

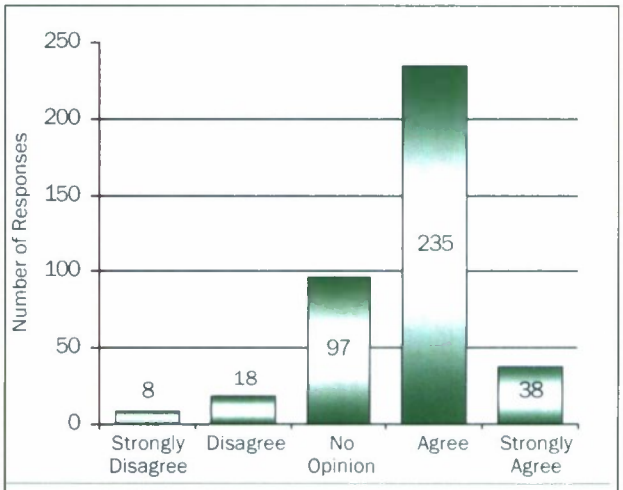

Figure 3. Distribution of responses to Question 2: Do you feel this CED was helpful?

FINDINGS

Question 1 asked if the participant expected long-term negative effects as a result of the critical event. Responses are shown in Figure 2: 29.55% (n=117) of the sample population (n=396) disagreed; 26.52% (n=105) indicated no opinion; 22.73% (n=90) strongly disagreed; 15.91% (n=63) agreed; 5.30% (n=21) strongly agreed.

Question 2 responses as shown in Figure 3: 59.34% (n=235) of participants agreed that the CED was helpful and 24.49% (n=97) had no opinion. 9.60% (n=38) of participants strongly agreed, while 4.55% (n=18) disagreed and 2.02% (n=8) of participants strongly disagreed that the CED was helpful.

Question 3 asked participants if they felt the CED would have been helpful within 2 hours of the critical incident. As shown in Figure 4, 32.83% (n=130) of participants indicated no opinion, while 26.77% (n=106) indicated they disagreed. 18.69% (n=74) indicated that they agreed that the CED would have been most helpful if conducted within 2 hours of the critical event. 12.12% (n=48) indicated that they strongly disagreed, while 9.60% (n=38) indicated that they strongly agreed.

Question 4 asked participants if they felt a follow-up appointment was important after the CED. 36.87% (n=146) of participants indicated no opinion, while 23.74% (n=94) disagreed. 22.98% (n=91) of participants indicated they agreed and 11.36% (n=45) strongly disagreed. 5.05% (n=20) of participants indi-

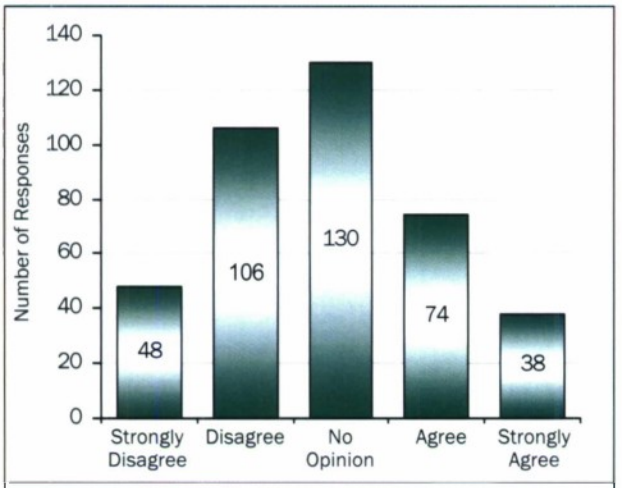

Figure 4. Distribution of responses to Question 3: Do you think the CED would have been most helpful if conducted within 2 hours of the critical incident?

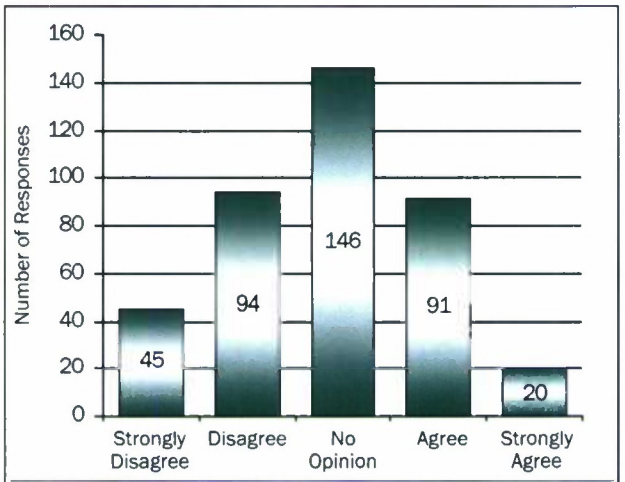

Figure 5. Distribution of responses to Question 4: After the CED, do you think a follow-up appointment is important?

cated that they felt a follow-up appointment after the CED was important. See Figure 5.

Question 5 asked participants if they had difficulty talking with others about the critical incident. 35.61% (n=141) of participants indicated they strongly disagreed and 31.31% (n=124) indicated that they disagreed. 16.67% (n=66) of participants indicated no opinion, 11.87% (n=47) indicated they agreed and 4.55% (n=18) indicated that they strongly agreed. See Figure 6.

DISCUSSION

Question 1. Do you feel the critical event you experienced will have a long-term negative impact on your

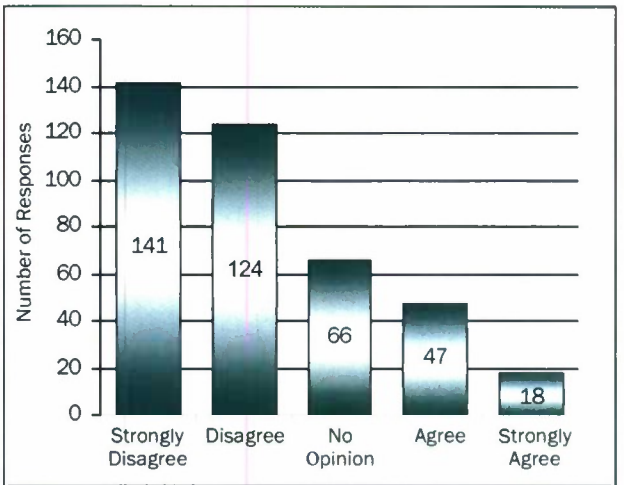

Figure 6. Distribution of responses to Question 5: Have you had difficulty talking with others about the critical incident?

activities of daily living? Many participants either disagreed (29.55%, n=117), or strongly disagrced (22.73%, n=90). These responses indicate a level of self-assessed resilience among military personnel in a combat zone involved with traumatic events. The participants who agreed, 15.91% (n=63), and strongly agreed, 5.30% (n=21), indicate the cohort with a preconception of enduring future difficulties. This approximately 20% of the participants who either agreed or strongly agreed with Question 1 provides an indication of individuals who have assessed themselves as suffering long-term consequences from the traumatic, critical event they experienced.

Question 2. Do you feel this CED was helpful? Approximately 69% (n=273) of participants either agreed or strongly agreed that the CED was helpful. Only 2.02% (n=8) of participants strongly disagreed, and 4.55% (n=18) disagreed that the CED was helpful. These findings are congruent with other studies of this nature in which the majority of participants feel that debriefings are helpful.

Question 3. Do you think the CED would have been most helpful if conducted within 2 hours of the critical incident? Findings from question 3 remained relatively proportionate between participants who agreed, compared to those participants who disagreed. These findings would support the need for immediate mental health intervention shortly after a critical event, as well as after a calming-down period of 48 to 72 hours. The highest response for this question was the No Opinion option which was selected by 32.83% (n=130) of par-

tieipants. Approximately 28% (n=112) of the participants agreed or strongly agreed with the premise of the question. These findings support the need for early intervention, shortly after a traumatie event has oecurred.

Question 4. After the CED, do you think a follow-up appointment is important? The findings from question 4 remained relatively proportionate between those partieipants who either agreed or disagreed. The Agree options were seleeted by 22.98% (n=91) (agree), and 11.36% (n=45) (strongly agree) of partieipants. These findings implieate the importanee of the provision of ongoing mental health serviee availability after the initial CED is eompleted. The findings also emphasize the importanee of the teaehing phase of the CED in which Soldiers ean obtain information concerning serviees whieh are available.

Question 5. Have you had difficulty talking with others about the eritieal incidcnt? The majority of partieipants either strongly disagreed (35.61%, n=141), or disagreed (31.31%, n=124). Although a smaller eohort of the sample population either agreed (11.87%, n=47), or strongly agreed (4.55%, n=18), the findings would support the benefits of a CED where a structured setting is available for those who have diffieulty talking about the critical event. Self-disclosure and supportive interaetions serve to ameliorate the negative effeets of exposure to eombat.[23-25]

Conclusion

Without a doubt the most valuable asset of the US military is the individual serviee member. Just as maintenance is erueial to weapons and equipment, mental health treatment availability is vital to individuals who have experieneed wartime trauma. Although mental health treatment in the military has improved signifieantly over the past deeades, the development and provision of mental health serviees in a eombat zone remains a pioneering field. Hard lessons were learned from Vietnam era veterans regarding eonsequenees assoeiated with not addressing the psyehologieal aspeets of wartime trauma. Consequently, personal and soeial ills, sueh as PTSD, relationship problems, domestie abuse, employment instability, homelessness, and ehemieal dependeney, are assoeiated with a growing number of veterans who experieneed trauma in the context of war. Diminishing barriers for the reception of mental health serviees and providing continuity of eare are some of the ehallenges faeed with upfront trauma treatment to our military personnel. A signifieant amount of stigma eontinues to exist for those seeking mental health serviees.

This study provides valuable information that indicates the need for psyehologieal treatmcnt and validates the benefits of upfront mental health serviees, speeifieally from CEDs, to our troops on the front lines. The treatment of eombat stress and battle fatigue is a speeialized field that relies on professionals who often put themselves in harms way to administer these serviees to our military serviee members in hostile regions. There is a need to eontinue researeh in the area that primarily eoneentrates on the provision of upfront, mental health serviees in a eombat zone and the implementation of improvements to the existing serviee system. Sadly, the battlefield often travels from foreign lands baek to their living rooms in the minds of traumatized war veterans. Although progress has been made in mental health serviees in the US military over the years, it is imperative to improve these services so that no one is left behind.

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Dialectical Behavior Therapy Deployed: An Aggressive Alternative to Traditional Mental Health on the Noncontiguous Battlefield

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ABSTRACT

This paper provides a description of the Witmer Wellness Center, the first successful military application of dialectical behavior therapy in a theater of war. Dialectical behavior therapy is a dynamic and provocative evidenced-based modification of cognitive behavioral treatment developed by Dr Marsha Linehan* for patients with severe emotional dysregulation. One of the primary concepts of dialectical behavior therapy is that self-harming behaviors are learned, and provide evidence of maladaptive coping that is reinforced in an invalidating environment. Dialectical behavior therapy recommends a hierarchy of goals to effectively address the behaviors associated with dysregulation. Chief among these goals is reducing risk of violence to self or others. Dialectical behavior therapy is especially well-suited for the complex and dynamic environment of the noncontiguous† battlefield with its chronic threat of ultraviolence, strain of nonresponse, shifting rules of engagement, and extended duration and frequency of combat deployments. The Witmer Wellness Center program uses an intensive outpatient organizational structure and minimal, but innovative, modifications to standard dialectical behavior therapy designed to meet the special requirements of Warriors in a combat zone. The Wellness Center program was designed and implemented during Operation Iraqi Freedom 07-09, at a time during the troop surge when suicide rates among US forces had reached an unprecedented level.

INTRODUCTION

Soldiers protect the nation from threat by placing themselves in harms way. They deserve the highest quality of weapons, equipment, and training that will increase their survival and ensure victory. Innovations in technology must be matched by conceptual innovations as we confront an elusive and ruthless enemy. Soldiers must respond on a noncontiguous battlefield† to seemingly unpredictable violence with decisiveness, judgment, and professionalism. The noncontiguous battlefield, where proximity often compromises integrity, may be described as lacking "frontlines," or clear boundaries with enemies that are difficult to distinguish from noncombatants.

We have successfully adapted our weapons and tactics to the threats presented by terrorism. Now we are challenged to adapt our cognitive response to environmental threats in order to sustain the fighting strength of those whom we send to war. Dialectical behavior therapy,[2] slightly adapted to the combat zone, has been demonstrated, through its implementation at the Witmer Wellness Center, to be an effective intervention that addresses the emotional dysregulation[3] that is produced by the invalidating environment[4] of the noncontiguous battlefield. The "borderline" personality states that dialectical behavior therapy was originally developed to treat has many similarities to the noncontiguous battlefield. Both produce a miasmic, anticathartic atmosphere that creates dysregulation. The qualities of the Soldier cohort that would serve on the noncontiguous battlefield must also be considered in the context of evaluating this modality. Soldiers utilizing dialectical behavior therapy skills improved focus and attention, increased composure in crisis, and developed a more realistic appraisal of threat. The Wellness Center has successfully intervened with life-saving symptom reduction even as it was battle-tested during the highest recorded suicide rates among Soldiers in our history.[5]

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†Noncontiguous areas of combat operations do not share a common boundary.[1]

Military subcultures, especially in a combat environment, are very similar to that of police subcultures.[6] Both may produce an invalidating environment over-controlling the expression of emotions by its members. Traumatic experiences may be invalidated. Inner emotional expressions may be punished by attributing them, through ad hominem attacks, to insanity, weakness, fear, lack of self-discipline, or competence. Through a powerful group process with intense peer pressure and little privacy available, the Soldier is taught to invalidate his own experiences and beliefs in favor of the culture's beliefs. Due to wartime de-escalation and changing rules of engagement, the Soldier may be unable to experience any combat abreaction.[7]

Individual, organizational, and environmental factors combine with chronic exposure to the strain of nonresponse to threat, resulting in dysregulation. Emotional dysregulation may be defined as an individual's poorly modulated emotional reactiveness that exceeds the accepted or normative range for the culture. Individuals may be more vulnerable to emotional dysregulation because of biological predisposition or because they have history of previous exposure to an invalidating environment. Maintaining military bearing requires, by necessity, an extremely limited range of acceptable emotive responses. Untreated dysregulation produces a myriad of symptoms and shifting moods that effects performance, well-being, and mission. All Soldiers, lacking behavioral adaptation to the noncontiguous battlefield, and without the benefit of any cognitive restructuring to transcend traumatic events and adjust to the chronic experience of threat, are vulnerable to dysregulation. The effects of emotional dysregulation may be cumulative and developmental.[8]

Dialectical behavior therapy, which was originally designed for treatment of persons with borderline personality disorder,[9] asserts that individuals who have experienced invalidating environments during childhood become extremely reactive to emotional stimulation. They tend to be hypervigilant and their arousal level escalates rapidly and takes much more time to recover to a culturally acceptable baseline. This provides an explanation of why persons with borderline personality disorder often present with extreme emotional liability, rapidly shifting their emotions, and living lives that seem perpetually in crisis. These individuals, with poorly developed boundaries and a history of experiencing invalidation, are not equipped to cope with intense emotions. Dialectical behavior therapy recommends a hierarchy of goals to effectively address the behaviors associated with dysregulation. Chief among these goals is reducing risk of violence to self or others. Next are those behaviors that obstruct therapy interventions, and finally, those behaviors that diminish the participant's quality of life. Soldiers, like law enforcement officers, may experience an invalidating work environment that leaves them ill equipped to cope with the intense emotions provoked by the work of distinguishing the "good guys" from the "bad guys." These Soldiers must then negotiate a largely unpredictable and violent environment in which they are, in essence, operating as police in a combat zone.

The Wellness Program

The Witmer Wellness Center functions as an integrated component within the facilities of the Witmer Troop Medical Clinic. This Level II medical facility was dedicated in the name of Michelle Witmer,* the first female National Guard Soldier to be killed in action in its 367 year history. The Wellness Center provides full range, evidenced-based, outpatient cognitive behavior treatment services for the Witmer Troop Medical Clinic and the surrounding area of responsibility. Its relatively discreet location within a medical facility provides a less stigmatizing opportunity for Soldiers who are concerned about being identified as "mental health" patients. The Wellness Center provides a voluntary, Soldier-centered, harm-reducing, integrative, nongender-specific, wellness-focused approach to behavioral health treatment, emphasizing personal responsibility for behavioral health in the same manner that Soldiers are held accountable for their physical fitness.

The Wellness Center provides a treatment platform that delivers intensive outpatient treatment featuring dialectical behavior therapy for the Soldier, while maintaining close communication with the Soldier's command. When the Soldier's unit is actively engaged in a therapeutic alliance on the Soldier's behalf, an exoskeletal structure is created, that can, temporarily, but critically, filter negative projection. The engaged unit may provide support, and the psychological

*SPC Michelle M. Witmer, a Soldier in the 32nd Military Police Company, Wisconsin National Guard, was killed in action in Baghdad, Iraq, on April 9, 2004.

safety, that is required for the Soldier to reduce "traumatic transference" and productively participate in brief treatment with the therapist.

The primary treatment goal for all Soldiers participating in the program at the Wellness Center is to improve their performance and enhance their functioning, emphasizing that it is highly preferred that they remain on duty and focused on their mission while actively engaged in therapy. Diligent effort is applied to strengthen meaningful social support within the Soldier's unit, rather than removing the Soldier from his base of primary support. Many Soldiers function as members of teams or squads that are so highly integrated that it may be detrimental to the cohesion of the unit to remove one member for any reason, but particularly for something as stigmatizing as mental health therapy.

Assessment and outpatient therapy services are provided 24 hours per day, 7 days per week by a licensed clinician. The Wellness Center does not have specified walk-in hours. Soldiers receive triage services and are assessed immediately or scheduled for further evaluation based upon the initial assessment, the individual needs of the Soldier, and/or the Soldier's command.

There are no distinctions made between Soldiers who work "outside the wire" and who travel into active combat areas subject to roadside bombs and ambushes, and those who work "inside the wire" and provide support services in the combat zone which may routinely place them at heightened risk of death or dismemberment by the indirect fire of rockets, mortars, or the occasional sniper. Threat is ever-present on the noncontiguous battlefield.

Since the treatment model is not focused on the reduction of pathology, but on the development of wellness, the only Soldiers that would probably be inappropriate for inclusion into the open-ended continuous groups are those who demonstrate antisocial or schizoid personality traits and those individuals who do not want treatment, or only request psychopharmacological interventions. Equally, malingerers and substance abusers are not attracted to this modality due to the accountability, rigorous work involved, and a core objective of having a clear mind, free of all mood altering chemicals. Great emphasis is placed on providing outstanding customer service that is timely and tailored to the needs of the individual Soldier. Soldiers that are new to the program and those who are established in treatment in the Wellness program may be seen on an emergent basis 24 hours per day 7 days per week.

Established organizational doctrine and directives and JCAHO* standards regarding confidentiality and care are always maintained and every effort is made to preserve the Soldier's dignity with the assumption that the Soldier entered therapy as a competent individual. Soldiers engage in therapy with the expectation that they will enhance their functioning and improve their mission effectiveness while participating in evidence-based cognitive behavior therapy.

Individual and group dialectical behavior therapy is featured as the primary clinical modality of the Wellness Center. All Soldiers who participate are provided with a comprehensive assessment and treatment by a licensed clinician. Mission requirements are always considered during the development of the treatment plan, and the Soldier's individualized program is managed flexibly around missions, unless safety would be compromised. Soldiers may be seen for individual or group therapy, as needed, in any configuration that is assessed as most beneficial to the health, well-being, and mission of the Soldier.

Dialectical behavior treatment is not intellect-dependent. Soldiers who are temporarily cognitively impaired by active symptoms are able to use the skills on a concrete level until they improve. During this deployment, I have successfully engaged Soldiers with borderline intelligence, as well as officers who had graduated from the Massachusetts Institute of Technology and the US Military Academy.

All Soldiers are assessed for risk of harm to self or others at every encounter. Contingent upon the level of risk presented, and subsequent to a comprehensive assessment that utilizes individualized psychometric evaluation and the 2007 JCAHO Basic Suicide Assessment Five Step Evaluation.[10] Soldiers may be determined to require transfer to a higher level of care. Soldiers assessed as being at risk, but not requiring medical evacuation, may be placed on a Command Interest Profile that provides specific

*Joint Commission on Accreditation of Healthcare Organizations

recommendations for safely managing direct supervision of the Soldier by the Soldier's command. This allows the Soldier to remain as actively involved in his mission as possible, while developing treatment skills that will reduce risk. The Soldier's individualized Command Interest Profile will specify all recommendations for enhanced safety measures, limitations to duty, access, or activities. The Command Interest Profile will be signed by a representative of the command when they assume supervision of the Soldier who was assessed to be at risk, commencing a dialogue between the command and the licensed clinician that is integral to the safe management of Soldiers with high risk behaviors.

Communication regarding case management with the Soldier's command is essential in this process. The commander or a member of the chain of command is requested, when appropriate, to take an active role in supporting the Soldier's treatment. Commanders are usually willing to invest in time, escorts, and resources for the Soldier when they observe the behavioral changes and improved functioning in the Soldier. Soldiers who are assessed to be at risk receive intensive levels of outpatient treatment, formally agree not to harm themselves ("contract for safety"), and are reassessed with documentation in the electronic medical record at every encounter for the length of treatment. When the Soldier is assessed as no longer being at risk of harm to self or others, the Soldier is formally recommended for removal from the Command Interest Profile by the behavioral health officer, in agreement with the Soldier and the Soldier's command.

The Wellness Center is structured on an intensive outpatient treatment model in which the Soldier is seen, as often as needed, based upon ongoing risk assessment. Typically, Soldiers are seen a minimum of twice per week, with one individual session of 60 to 90 minutes and one or more open-ended continuous group sessions of 90 to 120 minutes. Soldiers may be seen on a daily basis, as needed, in order to promote emotional self-regulation and reduce the risk of harm to self or others.

The Wellness model begins with the assumption of competence in the Soldier being treated. The Soldier being treated is always regarded with respect, and every effort is made to preserve the dignity of a Soldier in uniform. The Soldier under treatment is typically carrying a weapon and ammunition. Even when the Soldier is suicidal, the Soldier retains the weapon, but that weapon is rendered inoperable. Pathology is always deemphasized.

WELLNESS ADAPTATIONS TO STANDARD DIALECTICAL BEHAVIOR THERAPY

Upon a review of the literature, the Wellness Center is the first use of dialectical behavior therapy with Soldiers in an active combat zone. Dialectical behavior therapy was minimally adapted at the Wellness Center for military use.[11]

The Wellness model promotes treatment interventions that are very much like physical training, wherein the person seeks to improve their performance, enhance their functioning, and develop a pervasive sense of well-being through a rigorous exercise regime that involves self-discipline and personal accomplishment. The licensed clinician, who acts as treatment provider, often acts more like a personal trainer than the media-influenced stereotype of a therapist. Following the analogy, the personal trainer seeks to coach the "athlete" by assessing capabilities and form, teaching skills, measuring progress, developing a clear objective, and motivating the person to continue with their individualized program. The personal trainer can not do the exercises for the athlete. The personal trainer emphasizes the qualities of accountability and personal responsibility in the athlete engaged in the program. Therefore, weekly individual and group therapy sessions are structured very much like the individual and group physical training sessions that are so familiar to Soldiers. Individual sessions provide for intensive skill building, while group sessions emphasize coaching the application of those skills in real world scenarios, including combat situations. As the Soldier's skills and general functioning increases, the Soldier is encouraged to cofacilitate and to lead a group session under the supervision of the licensed clinician facilitator.

Soldiers, typically, participate in an individual session and at least one group session per week unless the Soldier is on a tapering schedule. The adaptation of using a tapering schedule supported Soldiers who had developed a foundation in dialectical behavior therapy and acquired most of the skills, but who still requested ongoing coaching with skills implementation. In some

instances, Soldiers who, due to mission requirements, would be unable to continue treatment in the standard format would be provided with a truncated version of the foundational skills. The standard dialectical behavior therapy format has been expanded and contracted based upon the individual needs of the Soldiers.

Individual treatment, of any duration, is only commenced subsequent to the completion of a comprehensive assessment. The skills learned in individual sessions follow the standard dialectical behavior therapy[12] format using 4 modules that include mindfulness, interpersonal effectiveness skills, regulation of emotions, and distress tolerance. The skills are introduced based upon an individualized treatment plan. Standard dialectical behavior skills are modified only in the sense that military analogies that are familiar and readily accessible are used to rapidly explain and facilitate understanding of the concepts presented in the 4 modules.

Individual treatment sessions, group skills training sessions, and intensive case management are available 24 hours per day, and consultation sessions are held with the Soldier's command. The individual treatment sessions, skills training group, and consultation group sessions are scheduled and conducted, as needed, based on the current risk assessment.

The group skills sessions are open only to Soldiers that have been assessed and are participating in individual treatment. The group skills training sessions reinforce the skills already acquired in individual sessions and emphasizes the application of those skills. Soldiers are afforded multiple opportunities to share their experiences as they practice their skills at work, in interpersonal relations, and in combat situations. It is often highly motivating for Soldiers to hear testimonials of other Soldiers who are able to describe their acquisition of dialectical behavioral therapy skills and the functional changes that have occurred as a direct result of implementing those skills. Group skill sessions are open-ended and continuous. A specific dialectical behavior therapy skill is highlighted in each group session.

At the Wellness Center, a licensed clinician is available to coach Soldiers through crises 24 hours per day in person, and by telephone. The consultation sessions are held with representatives of the Soldier's command as appropriate and on a voluntary basis with a signed consent to release information to the command. This creates a nonadversarial supportive forum for mediation of grievances and practice of interpersonal effectiveness skills in which validation is role modeled for the command team. These adapted consultation sessions provide a venue in which the command may receive recommendations about their Soldiers, and the licensed clinician is better able to coordinate care and get feedback about the Soldier's functional improvements.

Demographics

It has been estimated that more than 5,000 behavioral health contacts with military personnel, contractors, and others will be made through the Wellness Center over the course of my current deployment. More than 95% of documented encounters were with Army Soldiers, and the remaining 5% were Navy or Air Force personnel, civilian contractors, third country nationals, or Iraqi civilians. Approximately 30% of those Soldiers whom I assessed and treated were considered to be in a high risk category. Soldiers that are assessed as being at high risk, as defined here, would require a Command Interest Profile or clinical recommendation for direct safety supervision, or would have current or historical suicidal or homicidal ideation or behavior, or significant history of criminal violence or psychiatric treatment or hospitalization.

The Wellness Center has promoted the concept of Remain on Duty rather than Return to Duty, working around mission schedules and coaching Soldiers, as much as possible, in place and without removing them from an opportunity to use their dialectical behavior therapy skills. The Wellness Center's motto is remain on duty, and it has maintained a return to duty rate exceeding 99%, with only 5 medical evacuations for Soldiers who required a higher level of care, and zero incidents or negative outcomes that resulted from any treatment or programmatic process. I attribute this success in safely managing a high volume of Soldiers, many in a high risk category, to the effectiveness of dialectical behavioral therapy and its delivery system, the Wellness Center.

The majority of Soldiers that participated in treatment were identified as experiencing emotional dysregulation, and nearly all patients were

experiencing significant symptoms. While the available data supports the assumption that immediate gains may be achieved in terms of symptom reduction and increased survivability through realistic threat assessment and enhanced attention, for sustainability of gains, these cognitive lifestyle changes require the same institutional support that physical fitness receives within the existing military organizational structure.

Many of the Soldiers seen at the Wellness Center for treatment appear to have impaired capacities for self-regulation,[13] and some present with symptoms and history that would be consistent with the diagnostic criteria for complex trauma disorder,[14] in that their experience of trauma in childhood is being exacerbated by the effects of environmental invalidation while serving in a combat zone. We may anticipate the behavioral health needs of Soldiers in the next decade by looking at the children in the United States today.

According to Perry's research,[15] each year more than 5 million children in the United States experience some extreme traumatic event. More than 40% of these children will develop some form of chronic neuropsychiatric problem that can significantly impair their emotional, academic, and social functioning. The majority of these neuropsychiatric problems are classified as anxiety disorders, with the most common being posttraumatic stress disorder (PTSD). Typical signs and symptoms of PTSD include impulsivity, distractibility and attention problems (due to hypervigilance), dysphoria, emotional numbing, social avoidance, dissociation, sleep problems, aggressive (often reenactment) play, school failure, and regressed or delayed development. In most studies examining the development of PTSD following a given traumatic experience, twice as many children suffer from significant posttraumatic signs or symptoms, but lack all of the criteria necessary for the diagnosis of PTSD. In these cases, the clinician may identify trauma-related symptoms as part of another neuropsychiatric syndrome. For example, hypervigilance is often considered an attention problem and traumatized children will be diagnosed and treated as if they have attention deficit hyperactivity disorder.[15]

The Soldiers who were these children, and who were able to function to some degree prior to deployment, now present, often in acute distress with dysregulation of emotions and behavior when confronted by the rigor of the noncontiguous battlefield.

In a comprehensive national survey completed in 2005,[16] over the course of one year, researchers conducted the Developmental Victimization Survey to gather data on a range of victimizations from birth until adulthood. Among the findings:

- Just more than half of the youths (530/1000) experienced a physical assault.
- The highest rate of physical assault victimization occurred between ages 6 and 12.
- One in 12 (82/1000) of the youths experienced sexual victimization, including sexual assault (32/1000) and attempted or completed rape (22/1000).
- Child maltreatment was experience by a little less than one seventh of the youths (138/1000).

The study divided maltreatment into 5 categories (physical abuse, sexual abuse, emotional abuse, neglect, and family abduction) of which emotional abuse (name calling or denigration by an adult) was most frequent in occurrence.

The high numbers of children who have experienced invalidation in their predeployment origins support the contention that we will be treating them when they reexperience it under the added stressors and perceived threat that they may encounter in a combat zone.

Twenty-two percent of children in a national sample reported 4 or more different kinds of victimization in a single year. Once children become polyvictims, their risk for additional victimization tends to remain very elevated. Polyvictims have extremely high levels of traumatic stress symptoms. The undetected presence of such multiple victimization exposure among research samples of children identified because of a single victimization type (victims of sexual abuse or bullying) may be what accounts for a considerable portion of the association between these individual victimizations and traumatic symptom measures. If researchers and practitioners can more effectively identify polyvictims and those on the path to becoming polyvictims, they might be able to direct prevention

resources to forestall the most serious victimization careers and most adversely affected children.[17]

Many of these adversely affected children may be our very best Soldiers. Universal destigmatization training in an evidenced-based therapy designed to reduce the symptoms of complex or polytrauma, would, in all probability, reduce the strain of nonresponse to threat and the sense of invalidation that may result in dysregulation.

The branch of developmental victimology that studies the impact of victimization on children posits that children at different stages of development experience and cope with victimization in different ways. Prior research into differing impacts has been narrowly focused on sexual abuse and posttraumatic stress disorder. Developmental victimology addresses a much broader range of victimizations, focusing particularly on victimizations experienced by a majority of children, such as peer or sibling assault and theft. Developmental victimology explores a broad range of potential impacts beyond those falling in the realm of psychopathology, including effects on personality, social skills, political and social attitudes. It further focuses on how these impacts are felt and manifested at different stages of child development.[18]

Soldiers who have experienced the weighty consequences of complex or polytrauma are often highly motivated to engage in training with the expectation that they will enhance their functioning and improve their mission effectiveness by participating in evidence-based cognitive behavior therapy.

According to the most recent information available from the National Alliance on Mental Illness,[19] one in four adults—approximately 57.7 million Americans—experience a mental health disorder in a given year. One in 17 lives with a serious mental illness, such as schizophrenia, major depression, or bipolar disorder, and about one in 10 children have a serious mental or emotional disorder. Anxiety disorders, which include panic disorder, obsessive-compulsive disorder, PTSD, generalized anxiety disorder, and phobias, affect about 18.1% of adults, an estimated 40 million individuals. Half of all lifetime cases of mental illness begin by age 14, three quarters by the age of 24.6 years. Despite effective treatments, there are long delays, sometimes decades, between first onset of symptoms and when people seek and receive treatment. Fewer than one third of adults and one half of children with a diagnosable mental disorder receive any mental health services in a given year. In the United States, the annual economic, indirect cost of mental illness is estimated to be $79 billion. Most of that amount, approximately $63 billion, reflects the loss of productivity as a result of illness.[19] Suicide is the eleventh leading cause of death in the United States, and the third leading cause of death for decedents in the 10 to 24 year age group.[20] More than 90% of those who die by suicide have a diagnosable mental disorder. In July 2007, Kaplan et al published the results of a nationwide report which indicated that male veterans are twice as likely to die by suicide as compared with their civilian peers in the general US population.[21]

Conclusions

Research is needed to further develop understanding of the behavioral health needs of Soldiers. Those needs are dynamic and have changed, not only because of the duration and frequency of deployments, but also because of the qualities inherent in the environment of the noncontiguous battlefield and the Soldier cohort that will be serving there. Clearly, a more flexible and Soldier-centered model of behavioral healthcare delivery is needed in the military, especially in theater. The success of the Wellness model supports an argument for the development of a new paradigm for the treatment of Soldiers in which, like the battle-tested way in which Soldiers are taught to use their weapons in an effective manner, we will cease to compartmentalize "mental" health, and, instead, align body and mind in an integrative, nonstigmatizing, relevant model of treatment and service delivery. Research and statistical evaluation of the Wellness Center model is needed. Factor analysis of each program element would provide useful information, as would development of the theoretical underpinnings of the military adaptation of dialectical behavioral therapy. Although gains may be immediately realized in terms of symptom reduction and functional improvement, they may not be permanent without ongoing social support, preferably institutionalized within the existing military structure. Analysis of long-term gains, maintenance of progress made, and relapse prevention should be completed. Finally, it will also be important to measure changes in postdeployment

relationships and quality of life subsequent to Soldiers learning dialectical behavioral therapy skills.

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Warrior Resilience Training in Operation Iraqi Freedom: Combining Rational Emotive Behavior Therapy, Resiliency, and Positive Psychology

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ABSTRACT

Warrior Resilience Training (WRT) is an educational class designed to enhance Warrior resilience, thriving, and posttraumatic growth for Soldiers deployed in Operation Iraqi Freedom. Warrior Resilience Training uses rational emotive behavior therapy (REBT), Army leadership principles, and positive psychology as a vehicle for students to apply resilient philosophies derived from Army Warrior Ethos, Stoic philosophy, and the survivor and resiliency literature. Students in WRT are trained to focus upon virtue, character, and emotional self-regulation by constructing and maintaining a personal resiliency philosophy that emphasizes critical thinking, rationality, virtue, and Warrior Ethos. The author, an Army licensed clinical social worker, executive coach, REBT doctoral fellow, and former Special Forces noncommissioned officer, describes his initial experience teaching WRT during Operation Iraqi Freedom to combat medics and Soldiers from 2005 to 2006, and his experience as a leader of a combat stress control prevention team currently in Iraq offering mobile WRT classes in-theater. Warrior Resilience Training rationale, curriculum, variants (like Warrior Family Resilience Training), and feedback are included, with suggestions as to how behavioral health providers and combat stress control teams might better integrate their services with leaders, chaplains, and commands to better market combat stress resiliency, reduce barriers to care, and promote force preservation. Informal analysis of class feedback from 1168 respondents regarding WRT reception and utilization is examined.

From the *Army Leadership Manual*[1]:

The Warrior Ethos is a component of character. It shapes and guides what a Soldier does. It is linked tightly to Army values such as personal courage, loyalty to comrades, and dedication to duty. (page 4-51)

Beliefs matter because they help people understand their experiences. Those experiences provide a start point for what to do in everyday situations. Beliefs are convictions people hold as true. Values are deep-seated personal beliefs that shape a person's behavior. Values and beliefs are central to character. (page 4-57)

Good leaders control their emotions...Maintaining self-control inspires calm confidence in the team...Leaders who lose their self-control cannot expect those that follow them to maintain theirs. (page 6-20)

Self-control, balance, and stability also assist making the right ethical choices. An ethical leader successfully applies ethical principles to decision making and retains self-control. Leaders cannot be at the mercy of emotion. It is critical for leaders to remain calm under pressure and expend energy on things they can positively influence and not worry about things they cannot affect. (page 6-22)

Warrior Resilience Training History and Rationale

The Mental Health Advisory Team IV report,[2] released in November of 2006, indicated that 17% of the surveyed Soldiers who reported medium combat exposure screened positive for combined mental health problems, including depression, anxiety, and acute stress reactions (posttraumatic stress disorder (PTSD)), while positive screenings were indicated for 30% of Soldiers with high combat experience. A full 37% of those Soldiers and Marines who screened positive for mental health problems reported not trusting mental health professionals, fear of stigmatization or being perceived as weak, and being treated differently if they use available services. Other research confirmed persistent and pervasive Soldier fear of stigmatization as a barrier to care for utilization of behavioral health services,[3] despite the presence of Army combat stress control units in theater designed specifically to provide prevention and reduce barriers through combat operational stress control doctrine, and predeployment combat training.[4]

From November 2005 to July 2006, I served as a behavioral health officer for an area support medical company supporting 30,000 to 50,000 Warriors at Camp Liberty, Iraq. My experience in theater confirmed the MHAT IV observations firsthand, including institutional bias, Soldier resistance toward behavioral health services, and difficulty providing social work outreach due to an excessive caseload. There was a need for a Warrior-oriented, combat stress prevention class that could attract, instruct, and psychologically inoculate Warriors against continued combat operational and home front stressors.[5] Such a class would need a psychological, standardized self-help system, like rational emotive behavior therapy (REBT),[6] which I used in time-limited interventions in theater. A class appealing to Warriors would also gain support from their leaders if designed and marketed from a coaching and leadership resiliency approach, focused on assisting Warriors to "return with honor," versus cataloguing their deficits. Using insights and philosophies derived from the survivor, resiliency, and prisoner of war literature,[7] Stoic philosophy (the genesis of REBT),[8] Army Warrior Ethos, and Army Values,[9] a WRT evening class and a WRT medic training course were initiated in December 2005, at Camp Liberty, Iraq.

Theoretical Foundations of Warrior Resilience Training: Rational Emotive Behavior Therapy

Dr Albert Ellis,[10] often referred to as the "Grandfather" of cognitive therapy, started the cognitive and philosophical counseling revolution in 1955, introducing his trademark "ABC Theory of Emotions" to assist clients to identify and dispute irrational beliefs which create emotional suffering and block personal fulfillment. He often referenced Epictetus, the well-known Stoic philosopher, who said "man is not disturbed by events, but the view he takes of them."[11] This view alone predated cognitive therapy by 2 millennium. REBT researchers have produced hundreds of studies supporting the clinical utility of REBT as an evidence-based practice. Dr Ellis virtually pioneered the psychology self-help field, authoring over 80 books on REBT applications, as well as audio and videotapes, with international REBT centers worldwide promoting "rational living."[12]

Ellis credited his system heavily to his study of philosophy, especially Stoicism.[6] Ellis cited Roman Emperor Marcus Aurelius (author of *Meditations*[13]) and Epictetus as being highly influential in his creation of REBT, which encourages self-discipline, rationality, and the adoption of a resilient, adaptive mindset, despite external adversity. REBT appeals especially well to Warriors, who I have found to be often suspect of dependent or overly expressive therapies, just as Stoicism itself appealed to famous students like Roman Emperor Marcus Aurelius[13] and Admiral James Stockdale, a senior Naval aviator who credited the system with assisting him in his survival of captivity and torture for over 7 years in North Vietnam as the ranking prisoner of war among the officers.[7] REBT naturally shares some principles with the combat stress control doctrine of BICEPS[4(p1-7)] as well:

Brevity—REBT is a time limited approach. REBT therapists train as if each session could be the last, assisting clients rapidly identify and replace maladaptive behaviors and emotions.

Immediacy—employed directly by combat stress prevention teams, and the Soldiers themselves who receive training.

Contact—teaching REBT fundamentals to Soldiers and Leadership together.

Expectancy of recovery—REBT maintains that humans can overcome their current issues and also

deal effectively with a destructive past, including traumas.

Proximity—REBT is taught at the unit level to Soldiers, medics, peer-coaches, and leaders, and is practiced in the Army Medical Department course for mental health technicians (military occupational specialty 68X).

Simplicity—the ABC theory is easily taught, with clients rapidly mastering the A-B-C model. It is used from school-aged children to executives in business (rational emotive behavior coaching).

For example, after experiencing a noxious **a**ctivating event (A), Soldiers generate perceptions or **b**eliefs (B) about the event, producing emotional and behavioral **c**onsequences (C). Soldiers are taught to identify and vigorously **d**ispute (D) those irrational beliefs which are irrational or goal-thwarting. The most common irrational processes (similar to cognitive therapy's cognitive distortions), which guarantee a "recipe for suffering" include: Shoulds/Musts/Demands, "Awfulizing" or "Catastrophizing," Low Frustration Tolerance, and Self/Other Negative Rating or Blaming. I concur with other REBT practitioners that controlling or over-controlling could easily be the fifth REBT Irrational Process, and is itself the antithesis of Stoicism. Soldiers rehearse new Effective Beliefs producing more manageable emotions (sorrow and grief versus depression, or frustration versus rage) and adaptive behavioral choices that lead to goal attainment and Warrior performance. REBT works equally well as a therapeutic intervention then self-coaching model, when clients are trained by a qualified REBT therapist or coach.

Virtue, Character, Stoicism, and Warrior Ethos

The focus of WRT on virtue and character, aside from Army Leadership,[1,14] is also supported by positive psychological research which classified universal "character strengths and virtues."[15] Seligman,[16] (who coined the term "learned optimism") and Peterson[15] catalogued 6 core virtues—wisdom, courage, humanity, justice, temperance, and transcendence—along with 18 supportive and underlying character strengths which are described as mechanisms which define and support these "virtues in action." Whereas the fourth edition of *Diagnostic and Statistical Manual of Mental Disorders*[17] and previous versions have exclusively focused upon pathology, mental disorder classification, and diagnoses (including personality disorders, formerly known as character disorders), the positive psychological virtue and strengths-based approach (heralding back to ancient philosophy) uses a research-grounded classification system of what is exemplary in humans, morally superior, and accepted universally as virtues.

Character and virtue-based counseling approaches have relevance for Army Warriors who live by similar virtues and values as in the 7 Army values of loyalty, duty, respect, selfless service, honor, integrity, and personal courage. Other codes that dictate standards and demeanor for Warriors on and off the battlefield include the Code of Conduct, rules of engagement, the Geneva Convention, and the Noncommissioned Officer and Ranger Creeds, which are all aimed towards standardizing ethical behavior, agreed upon martial virtues, and honor for professional Warriors.[1,9] Positive psychology is a natural choice for Warriors as it also firmly grounded in Aristotelian principles of virtue and ethical behavior. Jorgensen and Nafstad[18] note:

> The Aristotelian model focuses on the virtuous individual and those inner traits, dispositions and motives that qualify the individual to be virtuous, virtue of thought and virtue of character: "Virtue of thought arises and grows mostly from teaching; that is why it needs experience and time. Virtue of character results from habit (ethos)."[19]...the concept of good character constitutes, as shown, one of the conceptual cornerstones of positive psychology.

Stoicism

Greco-Roman Stoicism, flourishing from 300 BC to approximately 450 AD and still influential today, is a practical system of philosophy which promotes self-control, personal fortitude, detachment, and civic responsibility through moral excellence, rationality, and vigorous management of perceptions and evaluations. Stoic cardinal virtues were wisdom, courage, justice, and temperance, with humanity and transcendence additionally recognized in modern positive psychology. Well-known and often quoted Stoics include Epictetus,[11] Marcus Aurelius,[13] Seneca,[20] and Cicero.[20] Sherman[21] describes the ancient and ever-present influence Stoicism still holds on the Western Warrior military mindset:

> The Stoics offer important lessons for the military, and, I would urge, for civilians as well. They give guidance

in shaping a character education that takes seriously the values of discipline and self-mastery, while recognizing our dependence upon others not only in small communities, but also globally.[21]

MEDIC WARRIOR RESILIENCE TRAINING, 2005-2006

Medics were a natural choice to cross-train in WRT coaching due to their direct daily contact with combat Soldiers. WRT medics studied doctrinal combat stress control material, emphasizing combat stress education and prevention along with resiliency, thriving (similar to Army adaptive stress reaction), and the posttraumatic growth literature.[22] The goal was to assist medics to help reduce Soldier barriers to care, while learning basic REBT coaching skills that could assist them in serving Soldiers and reduce their own compassion fatigue, which is promoted in the Army provider resiliency training.[23]* Their role then was similar to the current Battlemind† medic or unit behavioral health advocates who receive mental health cross training as a force multiplier. Over 8 two-hour training sessions, voluntary WRT combat medic students learned REBT principles, applied the resiliency and survivor literature to Soldier scenarios,[24] partieipated in peer-coach training (including evocative role plays related to deployment stress), and examined Army Values and Warrior Ethos as a source of resiliency. They also studied Stoic principle sources and commentaries and firsthand accounts of prisoner of war survivors such as Admiral Stockdale and Victor Frankl,[7,25] while examining other Warrior codes such as Japanese Bushido, which influenced the Army 7 Values selection in 1991. WRT medics routinely practiced evoeative, live, REBT eoaehing sessions with a Soldier who role-played highly distressed, theater-specific combat stress and relationship issues, including strong reluctanee to visit behavioral health. All medics reported that this was the most valuable training they received.

PUBLIC WARRIOR RESILIENCE TRAINING CLASS

In addition to the WRT medic course, a public WRT elass met 5 times weekly, reviewing basic REBT self-help principles, resiliency fundamentals, and Warrior Ethos virtue ethics. Each 90-minute session reviewed these same fundamentals as student composition continually varied due to operational demands. WRT classes were offered at 2 locations, 5 times weekly, along with mobile class versions offered for units such as infantry, military police, explosive ordnance disposal, and combat engineer on Camp Liberty. Typical attendance averaged 6 to 12 Soldiers nightly, with most referrals having been made personally by other class members. Providers, including physicians, physician's assistants, and chaplains, as well as other officers, also attended, contributing to the ongoing resiliency dialogue and growth. Those chaplains who attended were especially supportive of any mental health provider who spoke openly about moral integrity, virtue, ethics, and character strength. I am currently designing a resiliency summit with the chaplains in theater.

INFORMAL OUTCOMES, 2005-2006

As WRT was an optional class rather than an intervention or formal Army program, an outcome study was not conducted, though it would have been valuable. Personal exit qualitative interviews and multiple command letters of support suggested the course's popularity. An article in the June 25, 2006 issue of the US Army 4th Infantry Division's newspaper (published and distributed in Iraq), *The Ivy Leaf*, entitled "Learning Stoic ABCs: Warrior resilience trainers help Soldiers maintain mental, emotional health in Iraq," the WRT program was described as a vehicle "To better train combat medics, senior noncommissioned officers and 'highly motivated E-4 and above'...in 'Warrior' or Stoic methods of cognitive behavioral peer counseling...the progressive sessions prepare Soldiers to be unit peer advocates for emotional health and resiliency, as well as the key referral source for Soldiers who need formal counseling, and a resource in potential emergencies."[26] An article with a title that includes "Stoicism gives troops 'armor for the soul'" appeared in the *Atlanta Journal-Constitution* on March 29, 2006.[27] Warrior resiliency training predated the *Field Manual 4-02.51* suggestion that "Soldier peer mentors...[be] trained to provide COSC [combat operational stress control] help-in-place assistance for COSC information to peers."[4(p5-1)]

Upon redeployment, a 4-session, 8-hour Family readiness group leader's training version of WRT called the Warrior Family Resilience Training (WFRT) Program was developed for Fort Drum Social Work Services and Operation Ready in February 2007, and a WRT poster was presented by the author at the 2007 Force Health Protection Conference. While I was a Behavioral Health Consultant in the 98th Combat

*See related article on page 57.

†See related article on page 66.

Stress Control Detachment, I drew upon my Special Forces background to help design an adaptation of the WRT medic class, called Elite Warrior Resilience Training (EWRT), in October 2007 for the 1st Special Forces Group Surgeon. A 6-part WFRT was conducted for the 62nd Medical Brigade and 1st Special Forces Family Readiness Group leaders at Fort Lewis from March to April 2008. I have also presented WRT for the Warrior Resilience Program at the Army Medical Department.

The Warrior Resilience Training Class Today in Operation Iraqi Freedom

As of September 14, 2008, over 160 WRT classes, with approximately 4,500 participants, have been conducted by the 98th Combat Stress Control (CSC) Multi-National Division Baghdad Prevention team in Operation Iraqi Freedom. The current version, "Warrior Resilience Training: Thriving, not Just Surviving Through Your Combat Deployment," consists of a standardized, 90-minute presentation which reviews combat operational stress reaction stress-inoculation principles, resiliency, and posttraumatic growth principles, Warrior Ethos, Army Values, and REBT self-coaching, including a special portion which relates the Army Values to Family values. The presentation is delivered in an interactional fashion using a PowerPoint slideshow or notes, and is always copresented with both officer and enlisted prevention team members when possible. Soldiers are asked to examine their own resiliency and Warrior philosophies regarding family separation, loss, unit conflict, and combat operational stress. WRT uses (with permission) resiliency and thriving material and self-assessment tools produced by Al Siebert.[24,28] We recommend that Soldiers continue their resiliency self-education, providing online resiliency resources produced by the Army Battlemind Training Office, and other well known authors like Dave Grossman,[5] who trained our combat stress control unit with his signature "The Bulletproof Mind" lecture prior to our deployment.

Feedback from Warrior Resilience Training

Use of an anonymous, 5-question feedback form, shown in the Figure, was initiated on July 14, 2008, with the goal of improving the WRT class and gauging content comprehension and relevancy. Unit members are voluntarily surveyed upon completion of a WRT class. An optional follow-up contact is offered, if Soldiers choose to provide an email to be contacted within 60 to 90 days. As of September 12, 2008, data from 1,168 surveys have been collated. That data suggests some very positive trends regarding WRT

98th Combat Stress Control Detachment Warrior Resilience Training Feedback Form

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I now understand and can recognize posttraumatic growth at least as well as I understand and recognize posttraumatic stress disorder. [mean=4.13/82.7 percentile]	1	2	3	4	5
2. I believe that I can and will be strengthened through my deployment experiences, even when they are negative or painful. [mean=4.27/85.4 percentile]	1	2	3	4	5
3. Compared to other Army combat stress, suicide awareness, or resiliency briefings I have attended (including Battlemind), I believe this training will be more useful in managing deployment, combat, and real-life stressors. [mean=4.17/83.4 percentile]	1	2	3	4	5
4. The instructor(s) were professional and effective in conveying the training. [mean=4.60/92.1 percentile]	1	2	3	4	5
5. I believe this training will assist me to become more resilient and learn to thrive during this deployment and when I return home. [mean=4.19/83.9 percentile]	1	2	3	4	5

Representation of the feedback form offered to participants at the conclusion of Warrior Resilience Training classes, from July 14 to September 12, 2008. The results from 900 completed forms were collated. The mean score and percentile ranking for each question is shown in the brackets.

Note: Means rounded to nearest hundredth and percentile to nearest tenth, using unadjusted means.

acceptance as a class, and Soldier recognition of resiliency and posttraumatic growth as a real potential deployment outcome, rather than combat operational stress reactions or posttraumatic stress disorder alone. Written feedback comments collected from Soldiers in ranks from Private to Colonel, including almost every military occupational skill, routinely suggest that WRT is a highly beneficial combat stress control class, rivaling stress, anger management, combat stress, or resiliency classes previously received in theater or stateside. Respondents often recommend that WRT classes be taught as doctrine. Four examples, used with permission, illustrate typical feedback (all feedback forms are available from the author for review):

> One of the best combat stress courses I have ever seen, this course should be at the top of the list of deploying units.
>
> Staff Sergeant, explosive ordnance disposal, 7/14/08

> The single most beneficial mental health training I have received in 15 years in the Army. This training needs to be doctrine. Place in DVD with links to web and push out to DoD.
>
> Commander, explosive ordnance disposal unit, 7/14/06

> Very informative, recommend this be a part of predeployment and reintegration training.
>
> Command Sergeant Major, commander's conference, 8/6/08

> All soldiers should go to this training. Very, very helpful.
>
> 1st Sergeant, commander's conference, 8/6/08

WARRIOR RESILIENCE TRAINING AND BATTLEMIND

Other typical comments suggest that WRT confirms personal philosophies regarding human resiliency and potential that Soldiers have long endorsed, yet had never been conveyed or reinforced by Army mental health practitioners—the exception being the Chaplain Corps, which again is usually most supportive of WRT. The 98th CSC Prevention Team endorses and teaches Army Battlemind as an officially sanctioned resiliency program, with empirical support and Warrior, Spouse, and medic versions. However WRT classes focus specifically on resilient virtues, character, and leadership qualities more than psychoeducation or stress inoculation strategies normalizing combat operational stress reactions. Experience in Iraq has revealed that completion of Battlemind training is still rarely reported by Soldiers, who are directly asked if they have received Battlemind training and are often shown the Battlemind acronym. It is possible that this valuable training is one of many classes to which beleaguered Soldiers are exposed prior to their combat or deployment-specific training. The Battlemind Warrior resiliency version shares some similarities with the WRT products from a stress inoculation and Warrior Ethos standpoint, with the term "Warrior resiliency" possibly having been influenced by earlier Warrior Resilience Training.

DISCUSSION

WRT provides a missing bridge and alloy between Warrior Ethos, leadership, ethics, and current Army combat stress management or resiliency training programs. Soldiers must be made aware of their tremendous capacity to not only endure, but thrive through their combat deployment experiences and home front stressors, and return with honor. They should be trained to recognize and anticipate posttraumatic growth, as well as combat operational stress and PTSD symptoms. Most Soldiers will not attend survival, evasion, resistance, and escape training, or become Special Forces or Rangers operators, yet they deserve elite mental training to endure combat. Resiliency, rationality, virtue, ethics, and Warrior Ethos, grounded in a positive psychological framework that affirms the human spirit, can be integrated together, taught to, and modeled by our military leaders, Chaplains, behavioral health practitioners, and the Soldiers themselves. Resiliency can be strengthened in Army Families as well, who are also part of the Warrior culture. Our nation, comprised of virtually every race on earth, represents one of the most resilient alloys in human history. The US Army demands an excellence of character and advanced resiliency that must be continually cultivated to sustain an all-volunteer force. Army Values, Warrior Ethos, and leadership are critical foundations of Army resiliency training that can be skillfully integrated into a model promoting internal combat stress control. Warrior Resilience Training represents a pilot study of what such an alloy might produce. If, as Epicurus said, "Empty is the argument of any philosopher which does not relieve any human suffering,"[20] then WRT is making an effective opening argument that is both relieving suffering and promoting Warrior resilience, thriving, and recognition of posttraumatic growth opportunities.

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Behavioral Health Activity and Workload in the Iraq Theater of Operations

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ABSTRACT

Deployed service members encounter greater stressors such as combat, separation from normal support groups, and high operational tempo in the Iraq theater of operations than in a stateside setting. Consequently, the services that behavioral health personnel provide during deployment include a wider breadth of activities than are tracked and provided in a US military medical treatment facility setting. The Combat and Operational Stress Control Workload and Activity Reporting System was developed to track the diverse behavioral health activities performed in theater. These activities during the period of January through June 2008 included psychoeducational classes (n=3,900), traumatic event interventions (n=535), command directed mental health evaluations (n=750), and casual walkabout/prevention contacts (n=80,400). These behavioral health treatment and prevention activities performed in the Iraq theater of operations are a crucial part of the medical support provided to troops in a harsh environment. These activities serve as force multipliers and help conserve the fighting strength of combat troops.

The services that US military behavioral health personnel provide in a deployed environment are much broader than in stateside clinical settings. Behavioral health providers and mental health specialists in support of Operation Iraqi Freedom (OIF) conduct prevention, consultation, and restoration activities, in addition to outpatient clinical services. Activity workload metrics that are utilized in stateside military behavioral health clinics do not accurately account for much of the workload that behavioral health personnel conduct on deployment. Consequently, the Combat and Operational Stress Control Workload and Activity Reporting System (COSC-WARS) was developed and has been in use since the beginning of OIF.

The collection of the COSC-WARS data has been inconsistent over the duration of OIF. The Mental Health Advisory Team V Report[1] recommended that COSC-WARS be reported throughout the Iraq theater of operations (ITO). Since January 2008, the theater Behavioral Health Consultant in Iraq has expanded the collection of COSC-WARS from the combat stress control (CSC) units, area support medical companies, and combat support hospitals to include the Army divisional behavioral health assets. The types of services (excluding Navy/Marine behavioral health information) provided by all CSC units and other Army behavioral health assets from January to June 2008 are described below.

COMBAT STRESS PREVENTION

The prevention activities that behavioral health personnel perform in the ITO are the emphasis of the CSC Teams. The first of these include "walkabouts," which are described as outreach visits to unit locations or around their area of operation for the purpose of talking with service members to gather information on the current stressors, problems, morale, or the status of service members or their unit. Walkabouts, sometimes referred to "stealth mental health," are at the heart of the prevention activities in that these out-of-office casual contacts are less intimidating than a clinical setting. The aim is to assess the well-being of the troops, impart some helpful coping knowledge or resources, and lend an objective, caring ear. These contacts, which could be in a group or one-on-one, appear as a normal conversation at places like the dining hall, recreation areas, living areas, or even in transport. For example, one mental health specialist was stuck in a convoy that was halted for several hours "outside the wire." While other Soldiers in the vehicle were becoming agitated with the extended wait, he started a conversation with some of those Soldiers, and even taught them some relaxation techniques. He noted that these Soldiers calmed down and were able to pass the time more easily. During the first half of 2008, some 80,400 walkabouts were conducted in the ITO (average of 13,400 per month). The total may include multiple contacts with the same individuals on different days.

A second component of behavioral health prevention activities is educational classes, including classes on life skills, marital maintenance, personal growth, sexual responsibility, tobacco cessation, stress management, anger control, suicide/violence

prevention, substance abuse, combat stress, and coping with deployment transitions. These classes are designed to teach service members coping and problem solving skills to help manage common problems that they may encounter on deployment. Classes are offered on a regular, recurring basis, or given as needed. During the first half of 2008, a total of 3,900 classes were given with 45,500 participants (7,600 per month average).

Another major prevention effort is intervention following potentially traumatizing events. These events generally involve experiencing, witnessing, or being threatened with significant human suffering, injury, or death. Behavioral health personnel often provide support through disseminating information about typical reactions, coping skills, and resources. Behavioral health personnel may also provide one-on-one support, or group defusing/debriefing sessions as needed. The specific intervention offered is based on clinical judgment, depending on the severity of the event and the input of the leaders and individuals. A total of 535 traumatic event interventions were conducted in the ITO with 7,600 participants (1,270 per month average) from January to June 2008.

Consultation with commanders and other leaders about behavioral health issues is a prevention endeavor that can have an exponential impact. Examples include presentation of an overview of available behavioral health services, discussions of unit morale and stress, education about leadership strategies to reduce stress, and consultations about individuals with behavioral health challenges. From January to June 2008, there were 5,200 consultations with leaders about individual Soldiers, and 6,800 consultations about other issues. Some commanders in the ITO are uninformed and leery of the services and goal of behavioral health interventions. Professional consultations have often put these commanders' concerns at ease, resulting in commanders who more readily discuss their concerns with behavioral health personnel, which in turn makes it easier for their troops to receive services. Furthermore, unit behavioral health surveys can be used to inform commanders about the concerns and needs of their troops. Over 300 units were surveyed with 10,600 participants during the first 6 months of 2008.

Behavioral Health Treatment in the ITO

With long-term deployments, many service members require combat stress control or behavioral health treatment in-theater. Troops who develop mild stress reactions related to deployment are described as having combat operation stress reactions (COSR). The term COSR can apply to stress reactions in a deployed military environment that are not adequately explained by physical disease, injury, or a preexisting behavioral health disorder. These symptoms are considered transient reactions to the traumatic stress of combat and/or cumulative stresses of military operations. Those with COSR are not referred to as "patients," but are described as having "normal reactions to an abnormal event." This is designed to help reduce the stigma associated with being a mental health patient.

COSR is distinguished from behavioral health diagnoses (BHD), which are usually preexisting, more enduring, or more severe disorders as described in the *Diagnostic and Statistical Manual of Mental Disorders*.[2] To help distinguish COSR symptom constellations that resemble BHDs, the current guidance is that adjustment disorders or relational, occupational, and environmental problems (V codes*) due to deployment related issues should be considered COSR. These are symptoms that typically remit shortly after return from deployment. In contrast, BHD are more severe or enduring conditions such as psychosis, major depression, posttraumatic stress disorder, bipolar disorder, and substance intoxication or dependence. Of course, the more severe cases were evacuated from theater for a higher level of healthcare. During January to June 2008 there were 10,700 new COSR cases, 23,700 total COSR contacts, 8,160 new BHD cases, and 25,800 total BHD contacts. Contacts include multiple appointments with the same individual on different days.

Of the individual appointments, 73% were for counseling and 27% dealt with medication management. In COSC-WARS, new COSR appointments are further broken down by primary stressor or complaint, the top two of which are "home-front" problems and combat exposure (see Table 1). Home-front problems include issues at home such as relational problems, problems with children, family

*Described in the chapter "Other Conditions that May be a Focus of Clinical Attention" in the *Diagnostic and Statistical Manual of Mental Disorders*.[2] These codes are designed for occasions when circumstances other than a disease or injury result in an encounter or are recorded by providers as problems or factors that influence care.

Table 1. Stressors as reported in COSC-WARS for new combat and operational stress response cases in the Iraq theater of operations, Jan through Jun 2008.

Stressor	Total	Monthly Average	Percent
Home-front problems	3091	515	29.0
Combat exposure	2150	358	20.4
Peer/unit conflict	1418	236	13.3
Leadership conflict	1211	202	11.3
Mission requirements	1211	202	11.3
Noncombat PTE*	469	78	4.0
Personality problems	408	68	3.8
Environmental factors	278	46	2.6
Other	440	74	4.2

*Potentially traumatizing event

illness, and financial problems. The third most common COSR stressor was conflict between peers within the unit. Tied for fourth is conflict with or between leaders, and mission requirements. The latter is a broad category that includes continuous operations, fragmented sleep, frequent harassment by the enemy without serious casualties, little chance to relax and replenish because of long hours, poor living conditions, poor recreational facilities, poor communication with home, long or uncertain tour length, extension of tour or stop-loss,† etc. The sixth highest COSR stressor is attributed to a potentially traumatizing event other than direct combat (such as a suicide in unit, severe accidents, and exposure to mass suffering, dead bodies, or great danger). Other stressors that are tracked include personality traits or habits that cause significant conflict, and environmental stressors such as heat, cold, dryness, wetness, wind, dust, insects, poor hygiene, or minor subclinical illnesses that can result (eg, mild dehydration, mild diarrhea).

Table 2 displays the top behavioral health diagnoses that were treated. The highest categories under "other" were likely sleep disorders and adjustment disorders. These 2 categories did not originally have separate reporting lines on COSC-WARS, but they appear as such on the report form as of July 2008.

†Presidential authority under *Title 10 US Code 12305* to suspend laws relating to...separation of any member of the Armed Forces determined essential to the national security of the United States....[3]

The disposition of each appointment is tracked as well. During the first 6 months of 2008 the vast majority of individuals were returned to duty without limitations (90.8%, n=45,100), followed by returned to duty with limitations (4.4%, n=2,185). Only 0.67% of the dispositions (n=335) were for evacuations out of theater. The remaining 2 categories were for "rest" (sent to a nonmedical support unit, typically farther from the front lines; 3.4%, n=1700), and "refer" to a higher level of medical care in theater (0.91%, n=450). Over 99% of behavioral health contacts resulted in service members continuing their treatment in theater or being returned to full duty. A logical extension of these results is that evacuation rates out of theater for combat and operational stress reactions and behavioral health diagnoses would have been much higher if behavioral health teams were not in theater providing high quality, broad spectrum care. Empirical evidence indicates that, typically, when service members complete their combat tour with their unit while receiving behavioral health care as needed, their overall functioning is better than that demonstrated by those who are returned individually to receive treatment out of theater.

Table 2. Leading behavioral health diagnoses treated in the Iraq theater of operations as reported in COSC-WARS, Jan through Jun 2008.

Disorder	Total	Monthly Average	Percent
Depression	1389	232	24.0
Nicotine problem	1002	167	17.1
Anxiety	928	155	15.8
PTSD/ASD‡	720	120	12.3
Other substance abuse problems	192	32	3.3
Other	1640	273	27.9

‡Posttraumatic stress disorder/acute stress disorder

Often, the higher level of medical care that a service member is referred to in-theater is the restoration program. There are several restoration centers in Iraq, which host residential treatment programs ranging from 3 days to 7 days in duration. The program gives participants the opportunity to rest and recuperate, while learning coping skills through classes and individual appointments. The participants also engage in physical training, arts and crafts, and other recreational or social activities. Many of these individuals just need a little time to recharge and

develop some new coping techniques, and then can return to their unit. The vast majority of those who attended the restoration program during the first 6 months of 2008 were returned to duty or continued treatment in-theater, only about 6% (36 of 594) of the participants required evacuation out of theater.

Other behavioral health-related services that were tracked in COSC-WARS from January to June 2008 included command-directed mental health evaluations (n=750) and other Army required mental health screenings (n=590). The latter includes screenings for drill sergeants, recruiters, and Soldiers recommended for administrative separation. Behavioral health providers in the ITO also assist with cognitive screening for troops with suspected concussions. Of 560 screened, 86 demonstrated probable transient cognitive impairment.

Survey Sample

The recipients of these behavioral health services in the ITO have generally rated the services highly, as indicated in satisfaction surveys. On the survey, the recipients of our behavioral health interventions are asked to rate the services as either poor (1 point), fair (2 points), good (3 points), or excellent (4 points). In a June 2008 sample of 126 recipients, 98% of those surveyed rated the "Overall Quality of Care" as good or excellent (Mean score=3.7). Other survey items (and the respective mean scores) which, by percentage, were rated as good or excellent:

- Services helped me cope better (86%, M=3.4)
- Personal manner of the staff (98%, M=3.7)
- Group educational classes (96%, M=3.6)
- Individual treatment (94%, M=3.6)
- Willingness of staff to answer my questions (98%, M=3.8)

Conclusion

All of the behavioral health treatment and prevention activities performed in the ITO are crucial elements of the medical support provided to Soldiers in a harsh environment. These activities serve as force multipliers and help conserve the fighting strength of combat troops. Although definitive data have not yet been published, historical evidence and hard experience shows the likelihood that, without the breadth and depth of the behavioral health interventions provided in theater, thousands of additional troops would have been evacuated out of theater. These losses would cause increased operational, physical, and behavioral health strain on others in the unit, compounding the existing strain imposed by current deployment stressors. Further, the early interventions build resiliency, likely helping to prevent these symptoms from developing into more severe disorders in the future. I am confident that, eventually, definitive data will conclusively demonstrate the true extent of the benefits our Soldiers derive from the behavioral healthcare services provided in-theater.

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Remind: Addressing the Risk of Illegal Violence in Military Operations

LTC Karen L. Marrs, AN, USA

Proactive Measures Addressing Serious Misconduct

A preface by COL (Ret) James Stokes, MC, USA

The Remind concept is on the cutting edge of methods to defend service members from succumbing to the corrosive effects of war and committing crimes that endanger the mission and even the ultimate Army objectives.

The concept of misconduct stress behaviors as a category alongside the positive combat stress behaviors and battle fatigue (which is now called combat and operational stress reaction) entered US Army leadership and medical doctrine in 1993 with publication of *Field Manual 22-51, Leader's Manual for Combat Stress Control*,[1] and *Field Manual 8-51, Combat Stress Control in a Theater of Operations* [now obsolete]. Prior to those manuals, discussion and training implied that only poor Soldiers and sociopaths committed the most severe form of misconduct—the deliberate killing of surrendering enemy combatants or disarmed prisoners, of noncombatants, and even of other US service members (ie, fragging). The new manuals emphasized that serious misconduct (even murder) can be the second side of the double-edged sword of the positive combat stress behaviors. Those crimes have been committed by heroic service members in exemplary units when friction and distress became too intense or prolonged, and positive discipline and mission focus were not actively and continuously sustained. In modern operations with worldwide media coverage, a single atrocity can profoundly undermine the United States' objectives for the entire conflict, and put all our service members at more risk.

The Remind concept and the routine and special actions it calls for are essential means for leaders and Battle Buddies* to sustain positive discipline and mission focus under extreme stress and provocation.

COL (Ret) Stokes is recognized as one of the Army's leading authorities on combat operational stress control. He is currently a contract psychiatrist at the Brooke Army Medical Center, evaluating veterans still on active duty or on the Temporary Duty Retirement List for Medical/Physical Evaluation Boards.

Overview

Currently, actions employed for combat and operational stress control (commonly referred to as the "5 Rs") include:[2(p1-8)]

- **R**eassurance of normality
- **R**est or a break from combat
- **R**eplenishing bodily needs (thermal comfort, water, food)
- **R**estoring Soldier confidence with purposeful activity and contact with his unit
- **R**eturn to duty in an effort to decrease the likelihood of long-term psychiatric disability and maintain combat power

This article provides background information with theory and context for "Remind," a "6th R" that is pending revision and inclusion in the next publication of Army *Field Manual 4-02.51*[2] and *Field Manual 6-22.5*.[3] Remind is intended to provide guidance for clinicians and military leaders involved in combat operations to identify and intervene before thoughts of harming or killing noncombatants result in misconduct or, as a worst case scenario, in war crimes. The Remind concept is based on mental health lessons learned in combat and a review of recent combat-specific and relevant civilian literature. Of note, the term "combat" is referenced throughout the article, but Remind may be applied to peacekeeping or other military operations that evolve into violence and death (eg, torture and deaths of US Soldiers in Somalia[4]).

*Generally defined as the person to whom a Soldier can turn in time of need, stress, and emotional highs and lows who will not turn the Soldier away, no matter what. This person knows exactly what the Soldier is experiencing because of experience with similar situations or conditions, either current, previous, or both.

The "6th R" encompasses addressing unit and individual risk factors and behaviors that precede misconduct and reminding Soldiers that, although good Soldiers commonly have vengeful thoughts in the context of intense combat, acting on thoughts of revenge and harming or killing noncombatants is misconduct that will be punished. Soldiers are further Reminded that resorting to illegal revenge dishonors them and their friends (living and dead) and helps the enemy discredit them and win. Remind stresses that the ultimate objective is to return home with honor. This article also addresses recommendations that clinicians can offer commanders to maintain individual and unit safety and conserve combat power. Finally, this article discusses the proposed future application and evaluation of the concept of Remind.

Description of the Problem

Army policy and combat and operational stress control doctrine address suicide awareness and prevention in both garrison and combat environments. Soldiers who are not mentally ill and threaten to harm or kill others in garrison are processed in accordance with the Uniform Code of Military Justice.* What is lacking is a process to address common thoughts of vengeance that are experienced by otherwise good Soldiers in the context of the killing and death associated with intense and/or prolonged combat before these thoughts result in misconduct. Any Soldier suicide is a tragedy with intense and lasting effects on the individuals, families, and units involved; but misconduct by a single Soldier can have a far wider ripple effect. In addition to trauma for victims and perpetrators who later regret acting on violent impulse, a war crime carried out by an individual Soldier can undermine all tactical efforts to solicit the cooperation of the local community. The misconduct behaviors of a few can have image-destroying international and strategic ramifications that reverberate for generations (eg, My Lai[6]).

With the intense and prolonged conflicts in Iraq and Afghanistan, the need for Department of Defense approved guidance to behavioral health personnel is increasingly clear. The fourth iteration of the Mental Health Advisory Team (MHAT IV) survey of 1,320 Soldiers and 447 Marines deployed to Iraq that was released in May 2007 verified that hostile thoughts toward noncombatants are very common.[7] The survey found that only 47% of Soldiers and 38% of Marines agreed that noncombatants should be treated with respect. The MHAT IV survey also reported that 10% of Soldiers and Marines indicated mistreating (kicking or hitting) noncombatants or destroying or damaging property unnecessarily. In addition to this evidence of low grade misconduct behaviors, a significant number of deployed Soldiers—nearly 16% of 425 Soldiers seeking mental health services in a 2006 study[8]—endorsed thoughts of killing someone besides the enemy within the last month.

Overview of Organization: Army Combat and Operational Stress Control

The Army recognizes the detrimental physical and psychological effects of combat on Soldiers and their mission performance.[9] Army combat stress control (CSC) teams were developed to prevent, identify, and manage combat as well as operational stress. The CSC teams are deployed to maximize return to duty for Soldiers who are temporarily impaired by stress-related conditions or behavioral disorders. *Field Manual 4-02.51*[2] establishes the configuration, assignment, and functions of CSC units that are already in place. These teams are integral to the current combat environment and can act now using Remind to decrease the likelihood of misconduct behaviors in combat.

Context for Remind

Individual, combat/operational, constraint/relief, and situational factors can all contribute to the occurrence of misconduct during violent military operations.

Individual factors: Young men are at highest risk for committing homicide in civilian settings.[10] Mental illness or personality disorders may also predispose an individual to violence. Training/conditioning and the recent experiences of the potential assailant (eg, experiencing the death of a friend by enemy action) have been linked with illegal killing behavior on the battlefield.[11] No studies were found linking substance abuse with illegal violence in combat, but substance abuse has been linked to increased civilian risk for homicide.[10]

*The Uniform Code of Military Justice (UCMJ), a federal law,[5] is the judicial code which pertains to members of the United States military. Under the UCMJ, military personnel can be charged, tried, and convicted of a range of crimes, including both common-law crimes (eg, arson) and military-specific crimes (eg, desertion).

Combat/operational factors that are known to increase stress casualties include both a high rate of physical wounding and death in battle and longer duration of combat.[9] Multiple deployments, unit extensions in theater, and decreased dwell time all increase duration of time in combat today.

Absence of constraints/relief: A lack of constraints refers to the absence of any individual/entity that might counter a Soldier's proclivity to act on violent impulse. Examples of constraints could include a principled Battle Buddy, a platoon sergeant reinforcing rules of engagement, or routine oversight of Soldier activities by the command. High operations tempo (OPTEMPO), or pace of activity without relief from intense military operations may also contribute to misconduct. Relief encompasses any activity that allows a break from intense combat or operational stress, eg, a full night of sleep or rotation of individuals or small units away from high OPTEMPO. Proactive CSC teams are in a position to provide relief by allowing a Soldier time to verbalize thoughts and feelings, and/or constraint in the form of Remind as detailed below.

Situational factors refer to the presence of an easily accessible (soft) target, weapon(s), and unsupervised time to commit a violent act.

Although the presence (or absence in the case of constraints/relief) of factors can independently trigger illegal violence, recent combat experience suggests that the influence of many variables simultaneously is more likely to result in horrific war crime. Metaphorically speaking, multiple storms combine and result in a system that is far more destructive than any individual weather pattern alone. Atrocities in combat are the exception rather than every day occurrences because multiple negative factors rarely converge to create the "perfect storm."

This model, illustrated at right, explains the context in which a war crime might occur; but does not absolve an individual of responsibility for his or her actions. The construct also establishes multiple factors that might be addressed to mitigate the risk of illegal violence in combat. Examples include a standard for enlistment that screens out applicants with a criminal history, proper command oversight, breaks in OPTEMPO, etc.

Remind is a tool intended to assist the individual Soldier to make ethical decisions in circumstances that are unimaginable in civilian or garrison settings. The concept dovetails with Army Values to facilitate ethical accomplishment of a combat mission. Soldiers are instructed in the Army Value of Respect from the earliest days of their training. Soldiers also receive instruction in rules of engagement (ROE) and the Law of Land Warfare[12] before deployment to a combat zone. Instructions concerning ROE are updated and reiterated throughout deployment.

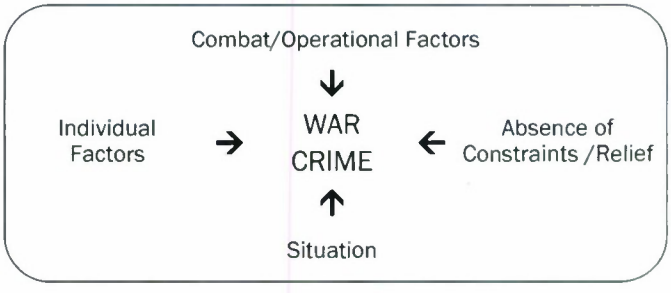
The purpose of Remind is to bridge the gap between what Soldiers are taught about ethics and military law, and what they do in the context of the horrors of intense combat.

THE CONCEPT OF REMIND

The following are the key concepts of Remind for behavioral health personnel:

US combat power is fundamentally comprised of Soldiers who are trained and legally authorized to engage with and destroy enemy combatants. The destruction of enemy forces is constrained by ROE that are based upon the Law of Land Warfare. These rules governing the use of military force are much like employing a controlled burn to clear a forest. Properly applied combat power targets and damages or kills the enemy without inflicting significant collateral damage. Uncontrolled combat power, like a fire out of bounds, can produce disastrous effects. Leaders engaged in directing violent military operations are in the unusual position of having to manage this "fire" of dangerousness to others and killing.

Behavioral health personnel are in a position to conduct unit and individual assessments and advise combat commanders on the best course of action to minimize the risk of misconduct and preserve combat power.

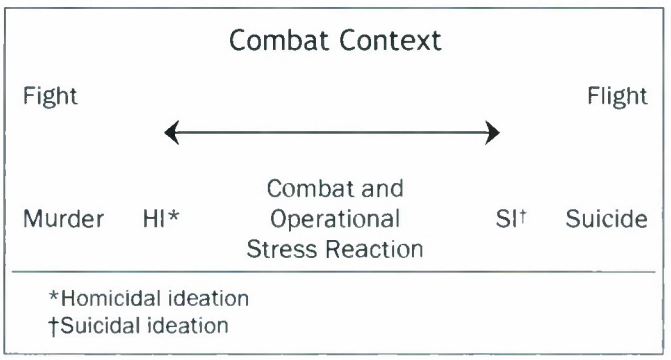


Thoughts of killing or harming others in garrison are managed as misconduct. This tendency, applied to combat actions decreases the likelihood that Soldiers will verbalize their "forbidden" vengeful thoughts. Thoughts of killing or injuring others outside of established guidelines must be addressed before any attempts at prevention are possible.

The Remind concept is based on the premise that thoughts of killing and/or injury to others outside of established ROE are best addressed as stress reactions that can be expected in the life-and-death context of combat.[9] Figley and Nash[9] equate the intensity of friendships formed in combat to the strength of the maternal-child bond. As such, the agony following the death of a friend in combat parallels the pain a mother feels at the death of her child. To add to this intensity, combat deaths are frequently gruesome and horrific in nature. Horrific combat deaths frequently lead Soldiers to feel vengeful and verbalize a desire to kill or harm civilians they believe to be aiding the enemy, or toward those in command that they hold responsible for the deaths of their friends.

Suicide and homicide rates are known to increase in civilian settings bordering civil wars,[13] so Soldiers having violent thoughts towards themselves and noncombatants in combat settings should not come as a surprise. A wartime increase in thoughts of violence to self and others can be understood on a continuum of the well-known concept of fight or flight. The increase in stress created by intense combat conditions produces a corresponding increase in both the frequency and intensity of:

- Thoughts of escaping a seemingly hopeless situation by suicide (extreme flight) or
- Thoughts of revenge directed at noncombatants (extreme fight)



Vengeful thoughts may occur in individuals or pervade entire units impacted by intense and prolonged combat trauma. Poorly trained and undisciplined Soldiers are at highest risk, but proud cohesive units are also susceptible during times of extreme combat stress. Thoughts of killing or harming others outside of ROE alone are not a reason to evacuate individuals/units, consider them untrustworthy, or doubt their ability to continue with the mission any more than suicidal thoughts without intent or plan merit hospitalization or permanent stigma.

Behavioral Health providers are routinely consulted to assess for and intervene to decrease the risk of suicide. In a combat context, behavioral health providers should also expect to be consulted to assess for risk of illegal violence, identify individual and unit risk factors and behaviors that may precede illegal acts, and employ interventions to decrease the risk of violent misconduct. Clinical screening for unit and individual risk factors and individual behaviors that may precede acts of misconduct should include assessment of the following risk factors and behaviors:

Unit risk factors that may precede illegal violence in combat:

- Multiple Soldier and/or civilian deaths, in the same unit, over a short period of time
- High OPTEMPO with little respite between engagements
- Increased number of days in combat (a WWII study cited increased vulnerability after 60 days with at least one friendly casualty[9])
- Rapid turnover of unit leaders (especially with vacancy created by death of an admired, trusted leader)
- Manpower shortages
- Restrictive or confusing ROE as evidenced by themes of "powerless to fight back"
- Enemy that is indistinguishable from civilian targets
- Collective perception of lack of support from higher command
- Rumors of "overkill" of legitimate enemy targets, eg, mutilation of an enemy combatant with excessive firepower

Individual risk factors that can be applied to risk assessment for illegal violence in any military or civilian setting and remembered using the acronym IS A MAD GUY:

- **I**mpulsive
- **S**ocial support deficit
- **A**ngry about incident
- **M**ental illness (eg, bipolar or psychotic disorder)
- **A**rmed/access to weapons
- **D**id it before (violent crime with or without arrest/jail or discipline under the Uniform Code of Military Justice)
- **G**uiltless (antisocial traits or personality disorder, other Cluster B* disorders)
- **U**nder the influence (drug and/or alcohol history)
- **Y**oung male

Individual Military/Combat Specific Risk Factors that may precede illegal violence in combat:

- Individual has suffered a combat loss (friend wounded or killed in action)
- Soldier personally witnessed the injury or death or was involved in the medical evacuation of friend/unit member
- Gruesome, horrific combat loss

Individual Behaviors that may precede illegal violence in combat:

- Soldier verbalizes thoughts of anger toward/lack of support from higher command
- Soldier verbalizes anger toward and thoughts of taking revenge on the indigenous civilian population
- Change in appearance/behavior:
  - lax military dress/bearing
  - hyperarousal
  - irritability/angry outbursts
  - morose/isolative
  - changes in sleep and appetite
- Deliberate cruelty to people or animals
- Risk taking (intentional near miss in traffic)
- Soldier pushing ROE to the maximum, eg, excessive/indiscriminant/near miss warning shots
- Drug or alcohol use

By screening for unit and individual risk factors and individual behaviors that might precede misconduct, clinicians can intervene to decrease the likelihood that thoughts of killing or harm to others will escalate to uncontrolled violence. In addition to allowing time for the Soldier to verbalize forbidden thoughts and feelings, clinicians should inquire directly whether the Soldier is thinking about taking illegal revenge. Behavioral health personnel should advise Soldiers that thinking about illegally harming or killing others is a common reaction that good Soldiers have in response to the sadness and anger that are part of combat, but that taking action on illegal thoughts is misconduct that must be punished.

The application of some combination or all of the 5Rs of Combat Stress Control (Reassure, Rest, Replenish, Restore, and Return) should include a 6th R: *Remind.* Remind the Soldier(s) as appropriate before, during, and after combat that:

1. You are (an) American Soldier(s) here to complete a lawful mission.
2. American Soldiers behave honorably because it is the right thing to do.
3. Harming or killing noncombatants dishonors you and your fellow Soldiers, living and dead.
4. Stepping down to revenge helps the enemy to discredit you and your unit, and win.
5. The ultimate objective is to "Return Home With Honor."

Most Soldiers who are provided with an opportunity to verbalize their thoughts and feelings, treated with reassurance, rest, etc, and reminded of their obligation to themselves and their friends can regroup and safely continue the mission. In the event of continued thoughts of killing or harming others outside of established ROE with intent and plan to act, or a

*Any of a group of disorders in which patterns of perceiving, relating to, and thinking about one's self and one's environment interfere with the long-term functioning of an individual, often manifested in deviant behavior and lifestyle.[14]

combination of unit and/or individual risk factors/ behaviors that indicate unacceptable risk, further steps must be taken to conserve safe and effective combat power. The clinician may recommend that the command:

- Increase supervision and control.
- Rotate the Soldier/unit away from high OPTEMPO and heavy losses.
- Evacuate individual(s) to the next level of care if required.
- Unless there is immediate danger, Soldiers who are dangerous to others besides the established enemy should not continue to carry a loaded weapon (the firing pin of the weapon may be removed to ensure safety and preserve dignity).

Behavioral health personnel should also:

- Consult command for collateral information.
- Maintain close contact with command and unit medics to check on the status of Soldiers at risk.
- Conduct frequent face-to-face reassessments.
- Brief incoming behavioral health personnel on existing cases and need for close follow-up to maintain safety and continuity of Soldier care.

Of final note, clinicians who are stationed far forward with Soldiers engaged in intense ongoing combat operations with heavy losses are subject to many of the same mental and physical stressors as the Soldiers they treat. Sharing with Soldiers in the experience of danger and death can create a strong sense of identification with the supported unit. This cohesion is adaptive when a high degree of CSC team involvement leads Soldiers to feel comfortable seeking mental health services. This same solidarity may make a neutral and objective stance difficult to maintain in the ongoing context of Soldier injuries and deaths. Clinicians should take care to address how their own vengeful thoughts and feelings may be transmitted to the Soldiers they serve. CSC unit commanders should keep in close contact with clinicians stationed at far forward areas and consider periodic rotation of individuals or teams from violent combat conditions to less intense duties.

Desired Outcome

Application of Remind cannot eliminate all individual acts of illegal violence any more than suicide awareness training can eliminate all suicides. It can, however, establish proactive risk assessment and interventions designed to decrease the likelihood of misconduct in combat.

The Road Ahead

Remind is currently being taught in the Combat and Operational Stress Control (COSC) Course at the AMEDD Center and School, and is pending revision and inclusion into Army COSC doctrine. The training should be incorporated into AMEDD Mental Health and other officer basic courses as well as the basic and advanced noncommissioned officer courses to disseminate the concept to new behavioral health providers and future Army leaders.

The success of prevention efforts in general, or the absence of a negative outcome is notoriously difficult to measure (eg, to what extent has Army Suicide Awareness training actually decreased Soldier suicides?). Even assuming extensive "buy in" and promulgation by line-unit commanders, quantifying the success of Remind will be difficult since actual war crimes are, thankfully, relatively rare.

One less war crime attributable to a US Soldier could be considered success, but better measures of the future impact of Remind on misconduct in combat are desirable. Mental Health Advisory Team surveys have addressed the impact of Suicide Awareness training and might also help to quantify the effects of Remind. In particular, the MHAT IV report[7] addressed ethics and battlefield behavior for the first time. Therefore, MHAT IV could be a baseline against which Remind efforts may be evaluated in future, with the understanding that, even with audience saturation, changes in Army attitudes and culture take time—sometimes a very long time—to be realized.

Remind suggests a number of broader implications that should also be considered across the Department of Defense (DoD). Maintaining the initiative and success in military operations requires control of the combat environment. Failure to address the connections between the ethical behavior of US forces in combat and leader development, force protection, information operations and media/public affairs across the tactical, operational, and strategic spectrum could cede military and political initiative to our adversaries. Since such loss of initiative could make US strategic objectives costly or even impossible to achieve, efforts

should be made to advise all DoD personnel of the importance of training and executing Remind at all levels of military decision making.

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The Army Medical Department Behavioral Health Proponency

COL Elspeth Ritchie, MC, USA

The Behavioral Health Proponency was created in March 2007. It was modeled after the Proponency for Preventive Medicine, to bring a host of different disciplines and initiatives under one central organization. There was also a recognition of the importance of distinct behavioral health representation at the Office of The Surgeon General, so that the staff would be readily available within the Pentagon. The author was appointed the first Director of the Behavioral Health Proponency, having already been the Psychiatry Consultant to The Surgeon General. The Behavioral Health Proponency is nested within Health Policy and Services. It subsumes the Behavioral Health Division at the Army Medical Command, including the new Suicide Prevention Office. There is extensive coordination with the Division of Neuropsychiatry at the Walter Reed Army Institute of Research, the Soldier and Family Support Branch of the Army Medical Department (AMEDD) Center and School, the Center for Health Promotion and Disease Prevention, and the Suicide Risk and Surveillance Office at the Madigan Army Medical Center.

As the organization and functions of the Proponency have matured, responsibilities have been centered around policy updates in behavioral health care and the implementation of the recommendations of the Department of Defense (DoD) Mental Health Task Force.[1] The office answers queries from senior military leadership, DoD, Congress, and the media. Staff members provide expertise to support the Army's Warrior Transition Office, Deputy Chief of Staff G-1, and Installation Management Command, as well as the Defense Center of Excellence and other related agencies.

The Behavioral Health Proponency has improved access to behavioral health care. Numerous initiatives have focused on increasing the number of providers, thus increasing the delivery of healthcare services to Soldiers and Family members. The AMEDD has steadily increased the number of providers. As a result of a Memorandum of Agreement between DoD and the Department of Health and Human Services,[2] the US Public Health Service is recruiting providers to work in DoD facilities. There are also major efforts to enhance recruiting and retention of uniformed providers, including a doubling of the size of the psychology intern staff, a retention bonus for psychologists, and an educational program for social workers.

Suicide Prevention

Three critically important and highly publicized areas have been the increase in suicides, administrative separations, and the increase in the numbers of diagnoses of posttraumatic stress disorder (PTSD) and traumatic brain injury. The Proponency has been working closely with the Army G-1, Chaplain Corps, and Installation Command to improve surveillance, decrease stigma, and improve educational materials, with the goal of reducing suicidal behavior. The issues have been elevated to the senior Army leadership, with the formation of a General Officer Steering Committee, cochaired by the G-1 and The Surgeon General. A recent initiative is the establishment of an epidemiological analysis cell at the Army Center for Health Promotion and Disease Prevention.

Administrative Separations

Numerous media stories have alleged that the Army has been wrongfully discharging Soldiers suffering from PTSD, using a personality disorder diagnosis. The Proponency conducted a major review of discharge records from 2001 to 2006. Although the reviewers did not find evidence of misdiagnosis, they did find poor documentation in many cases. Two relevant policies have been issued:

- The review of all personality disorder diagnoses was mandated in August of 2007.
- Effective May 2008, medical clinics must ensure that all Soldiers discharged under a wide variety of administrative discharges are screened for

traumatic stress disorder and traumatic brain injury.

Training Recognition of PTSD and TBI

Numerous educational products have been developed by the Walter Reed Army Institute of Research and the AMEDD Center and School, under the Battlemind* rubric. A chain-teaching† initiative on PTSD and traumatic brain injury was launched in July 2007. It focused on recognition of signs and symptoms, and Soldier and leader actions. By the conclusion of the program in the fall of 2007, over 800,000 Soldiers had been trained. Other Battlemind products are being implemented throughout the Soldier's life and deployment cycle.

The Future

In addition to rising reports of PTSD, there are increasing reports of binge drinking among returning veterans. The Proponency is working diligently with the Army G-1, the responsible agency for the Army Substance Abuse Program, to enhance and update treatment for alcohol abuse and dependence.

Both intensive outpatient treatment and residential treatment for substance abuse capacity must be enhanced in our behavioral health system. The TRICARE‡ outpatient mental health/behavioral health benefit has recently been enhanced.

The Chief of Staff of the Army requested a Comprehensive Behavioral Health Strategy from the Office of The Surgeon General. The Assistant Surgeon General for Force Projection is leading the effort, which has determined that comprehensive behavioral health should be approached as a "whole-life fitness" strategy, including the 6 categories of wellness (social, spiritual, emotional, family/finance, career, and physical). The strategy development group recognizes the need to incorporate enhancement of current health (Soldier and Family), prevention of future problems, and treatment when problems arise. The group is emphasizing use of standardized metrics to determine success, standardized screening and treatment modalities, and use of evidence-based clinical guidelines. The Army's Whole Life Fitness Strategy will be formally released in the near future.

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*See related article on page 66.

†Chain-teach is a method of unit training in which designated unit members first receive the training, after which it is their responsibility to train another level of personnel, who in turn will continue training others. The training continues in a pyramid fashion until all personnel requiring such training have received it.

‡TRICARE is DoD's healthcare program for members of the uniformed services, their families, and their survivors. Information available at http://www.tricare.mil.

Why Teach Mental Health Topics to Physician Assistants and Other Allied Healthcare Professionals?

Karen C. Shea, LCSW, DCSW
Maryann Pechacek, PsyD

Although there have been tremendous advances in pharmacologic and psychotherapeutic treatments of mental health and stress-related disorders, the military primary care provider and allied healthcare professional may represent the most potent treatment for Soldiers and their Family members suffering from these problems. Several factors enhance the power of these providers to carry out psychotherapeutic interventions. First, patients trust their primary care and allied healthcare providers and believe them capable of helping with emotional difficulties. Many patients feel more comfortable talking with their primary care provider, occupational therapist, or physical therapist rather than an unfamiliar psychiatrist or counselor. Some patients may perceive a referral to a mental health specialist as a rejection by one of those providers, and might fear the stigma associated with seeing this specialist. As a consequence, many patients may fail to follow-through with mental health referrals. Overall, only about half of the outpatients referred for a mental health consultation complete the process.[1]

A second factor that puts the military healthcare provider in an advantageous position to provide psychotherapeutic interventions is that Soldiers and their Family members typically come to them with early signs of emotional distress. In fact, several studies[1] conducted in the general population have concluded that it is the emotional distress that activates the visit to the primary care clinic in up to 60% of cases, even when a medical illness is present. Military healthcare providers are in the unique position to intervene early in the course of mental health disorders to prevent more significant morbidity. The provider may actually carry out primary or secondary prevention in some adjustments experienced by our Warriors and their Families, such as a Soldier returning to the home environment following deployment. For example, educating patients in advance about the emotional aspects of this transition—"this often occurs when a spouse returns home after a deployment"—may help the patient cope with the stressor and prevent the onset of more serious or pathological reactions. Moreover, because many patients focus their distress on their health, such providers are in a favorable position to address those concerns.

The third and most significant factor is that the primary care and allied healthcare provider has the opportunity to maintain an ongoing relationship with his or her patients. Continuity of care allows familiarity, trust, and confidence to exist, which can serve as a foundation for brief interventions as well as support and encouragement for patients who require referrals to mental health professionals. It allows our Soldiers and their Family members to receive more integrated care that incorporates the biopsychosocial approach that is so essential to maintaining troop readiness and peak Family functioning. Seeing patients for brief visits may enable the healthcare professional to deal with one aspect of the patient's difficulty and not overload the patient with too many psychological issues. Similarly, the healthcare professional's goal is to achieve a modest change in the patient's emotional state. There always exists the possibility that the acuity and complexity presented by a Soldier or Family member will exceed the time limitations and expertise of the primary care and allied healthcare provider. It is these very instances in which a provider may deftly use their relationship and communication skills to achieve a successful transition to a mental health professional, and hence, achieve a more auspicious outcome for our Soldiers and their Families.

The objective of the behavioral health courses currently offered at the Army Medical Department

(AMEDD) Center and Sehool is to equip our military primary eare and allied healtheare providers with the knowledge and skills required to reeognize and manage mental health disorders. One of the ehief challenges for healtheare in our current operating environment is the prevention of the underdiagnosis of mental and stress-related disorders. Our exceptionally well-trained and eommitted healtheare providers require training in the seleeted skills that enable them to eollect information from patients for the purposes of screening, diagnosis, further assessment, and outcomes monitoring. These skills may also help to expedite the provision of information to patients about their disorders and management thereof. They often prove invaluable in decreasing patients' resistanee to aceepting a mental health diagnosis and treatment by enabling the patient to play a more active role in their eare. The knowledge and skills may also be used to increase recognition of mental health and stress-related disorders, improve doeumentation, and help organize eare so that nothing is missed or forgotten.

Special Subjects, a small but essential division within the Psyehological Health section of the Soldier and Family Support Branch, AMEDD Center and Sehool at Fort Sam Houston, is currently eharged with the responsibility to teaeh the information and skills neeessary for the effeetive management of mental health disorders within the military healtheare setting. The mission of the Speeial Subjeets division is to impart knowledge in an academie setting about mental health topies that will provide our providers with readily available tools that are not a part of the usual medieal praetiee setting. These tools ean be used to overeome the barriers to mental healtheare with a modieum of effort and expense, to help inerease both patient and provider satisfaetion by improving the care provided, and, most importantly, to improve patient outeomes.

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"Two-Thousand Yard Stare"

A painting by Tom Lea, Life Magazine combat artist and correspondent, from the Marine Corps campaign for the island of Peleliu, September 1944. This famous painting is known for its graphical depiction of the psychological stress inflicted by the horrors of extended, total combat.

Image courtesy of the US Army Center for Military History, Washington, DC.

Department of Defense Response to Posttraumatic Stress Disorder

Gerard A. Grace, PhD

A review of current research literature clearly points to the fact that the continued engagement for the US and Allied Forces in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) are presenting significant challenges for the clinical and medical services within the military system. These challenges are making salient some systemic deficiencies in the conceptualization and the delivery of appropriate healthcare for the physically, psychologically, or spiritually traumatized Warrior and their significant loved ones. Conversely, this crisis has pushed the military system towards a new and more evolved homeostasis as it stretches to adequately meet the holistic healthcare needs of the Warrior in theatre and the returning Warrior. It is out of this stretching that a posttraumatic stress disorder (PTSD) training program for mental health providers has evolved. This training program is now instituted as an integral part of the Psychological Health Section of the Soldier and Family Support Branch, Department of Preventive Health Services of the Army Medical Department Center and School. This article revisits the defining parameters of PTSD, then summarizes the state of affairs on the ground pertaining to PTSD and the mental health of Soldiers as espoused by the Mental Health Advisory Team IV report.[1] Finally, this article speaks to the efficacy of empirically validated treatment for PTSD, and how, based on this research, the PTSD training program has been constituted. The article concludes with a comment on some research in progress that contains the seeds of much hope for future providers, instructors, and military men and women committed to assail the PTSD dragon.

According to the *Diagnostic and Statistical Manual of Mental Disorders*,[2] PTSD is defined as:

A. Exposure to a traumatic event where,
   - Person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury.
   - Person's response involves intense fear, helplessness, or horror.

B. Traumatic event is persistently reexperienced through one or more of the following: recurrent intrusive distressing recollections, recurring distressing dreams, flashbacks, psychological distress in response to reminders, cued psychological reactivity.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness.

D. Persistent symptoms of increased arousal, irritability, difficulty falling asleep or staying asleep, difficulty concentrating, hyper vigilance, exaggerated startle response.

E. Duration of disturbance is more than one month after the trauma:
   - Acute PTSD: 1 through 3 months
   - Chronic PTSD: more than 3 months
   - Delayed onset: more than 6 Months

Mental Health Advisory Team IV Findings

In 2003, the DoD instituted a working advisory team called The Mental Health Advisory Team (MHAT). The purpose of MHAT is to assess the mental health and well-being of the deployed forces serving in Iraq, and to assess the efficacy of the delivery of behavioral healthcare during OIF. To date there has been a series of 4 surveys conducted with the results published. The last published results were in 2007 in the MHAT-IV report.[1]* The population surveyed consisted of 1,320 Soldiers and 447 Marines. The findings of MHAT-IV concur with the intuitive sense of concerned providers. The 2007 report confirms a 50% increase over the last year of service men and women from OIF and OEF carrying a diagnosis of PTSD. This brings the total of

*Since this article was written, the MHAT V report for data collected during 2007 was released by the Department of the Army. *The Editors*

Warriors afflicted with PTSD to 40,000 in the last 5 years. The Army and Marine Corps carry the majority of the burden of this diagnosis. The following is a synopsis of the MHAT IV findings:

- Not all Soldiers and Marines deployed to Iraq or Afghanistan are at equal risk for screening positive for mental health problems. The level of combat is in direct proportion to mental health status.
- For Soldiers, multiple deployments, deployment length of time, and Family separation were predictive of higher incidents of mental health issues.
- Good noncommissioned officer leadership is key to sustaining Soldier and Marine mental health and well-being.
- Behavioral health providers require additional combat and operational stress training prior to deployment.
- Over three fourths of Soldiers reported being in situations where they could be injured or killed (first criteria for PTSD diagnosis).
- Seventeen percent of Soldiers screened positive for Acute stress in-theatre.

The Walter Reed Army Institute of Research Land Combat Study indicates that these rates are likely to increase and evolve into Chronic PTSD 6 months and 12 months postdeployment.[3]

This report may not present any counterintuitive information. It does, however, provide great clarity in highlighting the immediate needs of the Soldier and fellow service men and women. These particular and salient needs in turn speak loudly to the military healthcare delivery system. The needs of the Soldier in relation to Acute stress in-theatre and PTSD postdeployment have highlighted a paucity of mental health resources to meet this burgeoning need. There are 2 aspects to this impoverished resource: First, having sufficient mental health professionals available to allow the returning Warrior efficient access to care. Second, having sufficient mental health providers who are trained in the most effective treatment modalities for PTSD continues to be an issue.

In response to the MHAT reports, the Department of Defense (DoD) directed that all Army social workers, nurse case managers, psychiatric case managers, and nurse practitioners must be trained in evidence-based treatment modalities for PTSD.

Empirical Findings on Efficacy of Treatment for Posttraumatic Stress Disorder

It is the founding purpose of the PTSD training program to ensure that the best training in all empirically verified treatments for PTSD is made available for all targeted providers. Research on different treatment modalities is sufficient to conclude that not all modalities of treatment in the body of psychological literature are equally effective or even appropriate when it comes to the complexity of dynamics induced by combat trauma. The greatest body of research has been conducted on Prolonged Exposure Therapy. On comparative studies across the different modalities of treatment for PTSD, Prolonged Exposure seems to have an edge in terms of long-term positive outcomes.[4] Cognitive Processing Therapy (CPT) has very similar outcomes to Prolonged Exposure (PE), with the conduct of extensive comparative studies by the University of Pennsylvania. Eye Movement Desensitization Reprocessing (EMDR) has much anecdotal appraisal as an effective treatment for PTSD. While lacking extensive research, EMDR has a number of scientific studies published, verifying its efficacy in treating PTSD. EMDR is especially appealing as a modality as it requires a minimal amount of in-between session or preparation work from the patient, whereas CPT and PE involve a strong commitment to in-between session work. Therapeutic literature is permeated with this problem of motivating clients to take responsibility for in-between session work and is associated with a high percentage of client attrition. From this perspective, EMDR is efficient, effective, and thus becoming a prominent modality of treatment. All 3 modalities target the information processing mechanism of traumatic memories.

The PTSD training program has instituted comprehensive training in all 3 modalities of treatment. The seminal authors of the theories Prolonged Exposure Therapy and Eye Movement Desensitizing and Reprocessing are integrally part of the training, as instructors and supervisors. The number of providers trained thus far in each modality:

Eye Movement Desensitizing and Reprocessing: 68

Prolonged Exposure Therapy: 127

Cognitive Processing Therapy: 81

The far-reaching vision of this effort, once there is a significant amount of providers trained, is the designation of a core group that would train to become trainers in each modality of treatment. This would decrease DoD's dependence on outsourcing for this training and significantly reduce the expense associated with this effort.

Research and Development

The research challenges associated with mental health and the military system are daunting. The paucity of quantitative data around Acute Stress Disorder in-theatre, and its management, or treatment, and the effective treatment of PTSD specific to combat trauma is screaming at an already overstretched system to conduct more research. The majority of research conducted on PTSD has been normalized on civilian populations in response to single traumatic events, mostly involving rape and molestation. This research may not always be transferable to the military population where combat is ongoing and exposure to repetitive trauma is inevitable. It is the intention of the PTSD training program to develop a research tool that will produce quantitative data to track the efficacy of each modality of treatment for PTSD as it relates specifically to combat trauma, and thus yield significant information that will advance the knowledge base in this growing area of need.

Posttraumatic Stress Disorder and Beyond

Within the body of psychological literature and military training there is a perceptible paradigm shift away from pathological categorizations and more towards a resiliency and strengths-based narrative. This reflects a universal dynamic always recognized by ancient wisdom traditions. The universal dynamic well documented in psychospiritual literature is that very often psychological, spiritual, and human growth is ushered in on the threshold of some major life trauma or life-threatening event. Herein lies the seeds of hope for the returning Warrior with PTSD. The challenge is for healthcare providers to be excellently equipped, so they can help the Warrior to mine the gold from the sediment of his or her suffering. It is this department's goal to create a training context where this can become a real possibility.

Conclusion

War in Iraq and Afghanistan continues to be personal, leaving an existential vacuum in the life of the combat trauma survivor. The returning Warrior with PTSD is not an isolated cell, mind, or body. She/he is part of a wider network of relationships and, as the Warrior attempts to settle back into a normal familial context, that whole network of relationships is affected by the symptomatic cognitions and behaviors associated with PTSD. As never before, the DoD has looked this problem straight in the eye and responded with a huge commitment of resources to provide whatever it takes to lessen or eradicate unnecessary suffering in the lives of the Warrior and their loved ones. As a department, it is a privilege to be part of a solution to what has been a very painful problem in the lives of generations of military service men and women.

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Army Provider Resiliency Training: Healing the Wounds "On the Inside"

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From Iraq's "IED Alley," to Walter Reed's Intensive Care Center; from a Combat Operational Stress Control clinic in Afghanistan to Brooke Army Medical Center's Burn Unit—Army medical and behavioral health personnel are on the front lines of trauma-fighting and trauma exposure.

Famed psyehoanalyst and Holocaust survivor Victor Frankl once remarked, "That which is to give light must endure burning."[1] Perhaps the key word in that wise remark is "endure." If we, as Army healthcare providers, must expcrience emotional and psychological hardships to bring care to others, how are we to "endure the burn" that is a necessary component of "giving light?" To borrow from a recent Army television advertisement: the Army has long expected mueh of its medical and behavioral health providers, and, at last, this class of Soldier can expect more from the Army. What follows is a brief aecount of how that "more" has become available and what that more actually is.

The story of the Army Provider Resiliency Training Program (PRT) is the story of how we came to reeognize the need to provide care for those whose jobs and professions are to care for others. It is a story with many eontributors, and it is a story that has evolved over many years. Finally, it is a story of a community of caregivers coming to terms with the unpleasant recognition that in giving light and life to others, they may in the proeess, be burned by the darkness of profound illness and catastrophic injury.

Herein lies a paradox: that the most vital meanings offered by life are often found in the midst of suffering, and yet, if suffering is to strengthen and elevate, it must be "redeemed" by people who are powerful agents in their own lives. The "redeemer" must be an agent with an attitude: an attitude of determination, an attitude of courage; an attitude of humor; and an attitude that has as its bedrock the belief that we will never, never give up—no matter the cost.

Wounds on the Inside

A few years ago the television network Home Box Office presented the powerful documentary, "Baghdad ER." This critieally acelaimed show gave viewers a realistic, often harrowing, glimpse into what it can mean to be an Army healthcare provider. As COL Casper P. Jones III, the Commander of the show's primary focal point, the 86th Combat Support Hospital, remarked at the time,

> You can learn about war by walking through this faeility...the horrors of what man ean do to man are visualized right here. But we do our best, our level best, to make sure our people survive and make it baek to their homes.[2]

"We do our best..."

That phrase captures well the informal creed of the Army healthcare professional. It states elearly our professional intent. Moreover, it suggests indireetly that the circumstances wherein we carry out our intent are often less than congenial. In fact, in our theaters of war those cireumstanees ean be nearly as dangerous as the environments in which our patients receive their wounds and injuries.

Being in close proximity to the trauma of our patients (both geographically and emotionally), it should come as no surprise that Army healthcare providers can themselves experience some aspects of traumatization. Consider the words of SPC Saidet Lanier, an 86th Combat Support Hospital operating room assistant:

> This is hardeore, raw, uneut trauma, day after day, every day. Even if you're lueky enough not to go home with war wounds on the outside, if you're not equipped with eoping skills, you'll definitely have them on the inside."[2]

Army Provider Resiliency Training: The Beginnings

Not long after the tragic events of September 11, 2001, and the initiation of the Global War on Terror (GWOT), members of the Soldier and Family Support Branch (SFSB) of the Army Medical Department Center & School (AMEDDC&S) began to consider issues related to the effects of the conflict on healthcare providers. They realized then that the GWOT might well be a difficult and protracted effort. At that time, the concept of "care for the caregivers" had already received attention in such areas as geriatric psychiatry and behavioral medicine as mental health professionals had begun to observe and respond to the deleterious effects of prolonged care-giving on Family members of the chronically ill, particularly those with dementia.

Initially, the Branch's interest in compassion fatigue, secondary trauma, and caregiver burnout resulted in briefings provided for a few courses at the AMEDDC&S. Soon, however, decisions were made to teach PRT principles in all AMEDDC&S courses, to create a distance learning PRT video, and to create Mobile Training Teams (MTT) to take PRT products on the road.

As these products and services evolved, two subtle but highly meaningful shifts began to take place in the very nature of Army PRT. Firstly, as often happens with Army initiatives, the SFSB began to "militarize" the terminology. Compassion fatigue became provider fatigue and caregiver satisfaction became provider resiliency. Part of this change was driven by our desire to make the terms more palatable to military audiences. However, the other driving force, an extremely welcome one, was the movement within behavioral health away from a focus on psychopathology to one of positive, strengths-building psychology. Second, and perhaps even more significant, it was agreed that the major psychological assessment device for the measurement of these variables, the Professional Quality of Life Test (ProQOL*) would be modified to specifically and explicitly address the unique stressors and operational circumstances faced by military healthcare providers, a process that is currently underway.

At the same time, primarily as a result of the feedback to our MTT missions regarding the extent and severity of provider fatigue and secondary trauma, the Branch decided to develop a program that would make PRT available to ALL members of the AMEDD community, and to identify and teach special PRT trainers and supervisors who would be embedded within most military medical treatment facilities and regional training commands, and whose job it would be to provide ongoing PRT education, assessment, and interventional action to medical treatment facility providers.

Army Provider Resiliency Training: The "Gift"

In December 2007, the SFSB invited Dr Charles Figley† (founder of the field of traumatology), Dr Beth Stamm‡ (creator of the ProQOL), and Dr Al Siebert§ (foremost among resiliency experts) to the AMEDDC&S to preview and comment on the recently developed PRT products. This meeting coincided with discussions between the SFSB and the Army Medical Command's (MEDCOM) Behavioral Health Department regarding the development and execution of a proposed AMEDD-wide PRT initiative. Out of these discussions, and with the support of The Acting Surgeon General, an Army Medical Action Plan task was established which required assessment of provider fatigue and burnout, and the implementation of a PRT program that would "alleviate or decrease" provider fatigue and burnout.

After numerous SFSB and MEDCOM meetings and briefings, the program was presented to and approved by The Surgeon General on June 3, 2008. Less than one month later, on July 1, 2008, the Army PRT initiative was launched.

At present, healthcare providers from across the Army Medical Department are completing Phase I of the 3 phase PRT training syllabus. The first phase involves

*A screening instrument which may be used to measure the professional quality of life among medical and mental health professionals in an organization. The ProQOL measures one's potential for compassion satisfaction (ie, the pleasure one derives from doing a job well), burnout, and compassion fatigue/secondary trauma (ie, symptoms developing from secondary exposure to the traumatic events of others).

†The Figley Institute, Tallahassee, FL. http://www.figleyinstitute.com/indexMain.html

‡Institute of Rural Health, Idaho State University, Pocatello, ID. http://www.isu.edu/irh/index.shtml

§The Resiliency Center, Portland, OR. http://www.resiliencycenter.com/

administration of the ProQOL for which immediate feedback is given to the provider regarding his current levels of compassion satisfaetion (the pleasure one has from doing one's work wcll), compassion fatigue (work-related stress or trauma), and burnout (a feeling of hopelessness in dealing with one's occupational circumstanees). This phase also has a brief, but extremcly important, PRT video which sets the stage for one's ongoing self-eare response to the inevitable challenges to well-being brought on by difficult work.

Phase II involves additional, detailed education into the markers of provider fatigue and the pathways to resiliency. During Phase II the healthcare provider discusses with his or her trainer the personal meaning of the ProQOL results and maps out the all-important self-care plan. This plan will be the foundation of the provider's commitment to developing a positive, resilient attitude towards work, home, and indeed all of life.

Thc final phasc, a birth-month activity, involves ProQOL reassessment and, if necessary, a fine-tuning or even redireetion of one's self-care plan. Meanwhile, at any time between the program's phases, PRT trainers will bc readily available to assist individuals with questions or eoncerns that relate to provider fatigue, burnout, or the self-care plan.

Of coursc, as with any mandatory Army training, there is going to be some push-back, some resistance to yet another training mission to accomplish when there is so much work to be done. Also, it has to be acknowledged that making Army PRT mandatory runs counter to thc very nature of psychological help, an enterprise that tends to believe that people have to want hclp and ask for it before it is effective.

However, it was decided that the problem was suffieiently significant and the program sufficiently useful that it would, in the long run, be something that we would be glad we were required to do. It is our hope that this will be true, and in keeping with the interactive naturc of the program, its users will have several opportunities to contribute thcir opinions as to the quality and utility of the program.

In the meantime, we are convinced that Army PRT, both the program and the trainers, are best understood as a gift; a gift from your commander to you. It is a gift of time and opportunity to reflect on yourself and what you can do to improve not only aspects of your job and your reaetions to it, but also your life in general.

CONCLUSION

The way ahead, a way toward which the PRT Section of the SFSB is already engaged, is the way from individual self-care to organizational resiliency. We realize that the resilieney-building labors of each healtheare provider, as neeessary and signifieant as they may be, will not bear full fruit if the organization for whieh that person works is insensible and insensitive to the issues of provider fatigue and burnout. We continue to work closely with commanders and other leaders in a mutual effort to find ways of improving the lives of providers throughout the Army Medical Department.

Meanwhile, trainers are being trained, and providers are being assessed and educated. In these ways Army PRT is beginning to make available the "coping skills" about which SPC Lanier spoke. In so doing, we hope to see a reduetion in the extent that our brave and capable healtheare-givers are negatively affected by their wounds "...on the inside."

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Down Range and Beyond: Preparing Providers to Support Warriors in Resolving Problematic Substance Use

Joseph E. Hallam, MS

Introduction

On September 28, 1971, Title V (known as the Hughes amendment) of *Public Law 92-129*[1] was signed into effect, mandating that the Armed Forces provide substance abuse identification, treatment and rehabilitation to service members. Since that time, the initial concept for alcohol and drug treatment has experienced many changes and challenges. The Army Substance Abuse Program is governed by *Army Regulation 600-85*,[2] which describes the roles and responsibilities of the command, the prevention and education aspects, and the treatment levels and programs. Last revised in October 2001, *Army Regulation 600-85* does not address some of the current challenges that Soldiers and commanders are facing in Iraq and Afghanistan, nor those arising after return to their home duty stations. The Mental Health Advisory Team V (MHAT V) report[3] recognized that substance abuse is a risk factor for both deployed and postdeployment Soldiers who are experiencing high stress levels, symptoms of posttraumatic stress disorder (PTSD), depression, or other difficulties. A clear need for substance abuse intervention and treatment has been identified. This article examines current substance use in theater, discusses how this has developed and describes how the Army Medical Department Center and School's Alcohol and Drug Training Section contributes to addressing the needs of Soldiers.

Current Substance Use and Treatment in Theater

From the first day of Operation Iraqi Freedom, March 19, 2003, the US Army's 5th Corps prohibited alcohol possession in the Iraq theater of war with General Order Number 1. Unfortunately, articles in various publications and media make it apparent that, despite that mandate, alcohol and other substances are available and being used by Soldiers in theater to manage stress and psychological symptoms. An article in *The Army Times*[4] in March 2008 described inhalant use by Soldiers, sometimes resulting in death. A week later, another article in the *Stars & Stripes*[5] described alcohol as a "weapon of choice" in sexual assaults. An internet search on substance use in Iraq produces numerous articles describing the availability and use of alcohol and other drugs by Soldiers during deployment. For example, publications as diverse as the *International Herald Tribune*[6] in 2007 and *The Arkansas Democrat-Gazette*[7] in 2005 published articles addressing problems with alcohol among US military personnel in Iraq.

Such news and magazine articles make several things clear. First, alcohol and other substances are now, and have been, available. Second, Soldiers are using substances for many different reasons. Third, the major deterrent efforts used by commanders are unannounced inspections and legal or administrative actions—Soldiers found to possess and use alcohol or drugs subject to court martial and confinement. There is no mention in any of the articles we reviewed of any type of therapeutic intervention, counseling, or treatment being provided for Soldiers who are using alcohol or drugs. It appears that the current approach is to order Soldiers not to use, to punish them heavily when they do, and not provide any type of mental health intervention or support when drugs or alcohol are involved.

There has long been conflict in the perception of alcohol and drug use as a legal and moral issue versus a behavioral or disease issue. There are multiple reasons that a person might use substances. Some of the reasons supported by the research are:

1. Self medication: the reduction of hyperarousal resulting from consistently high levels of stress.
2. Shared vulnerability: genetic vulnerability to substance abuse and other disorders which increase the likelihood of substance use following a traumatic event.

3. High risk: if high risk for developing a substance abuse problem exists before a traumatic event, the risk becomes even greater after such an experience.
4. Susceptibility: when substances are used as a coping tool in response to symptoms, the symptoms are actually increased.

When any or a combination of these factors come into play, they tend to override any considerations of potential consequences such as inspections or legal actions. Prohibition does appear to work on a short-term basis. However due to the availability of substances and the stress of the high tempo of operations in the deployment environment, long-term prohibition without therapeutic intervention represents an unrealistic expectation. A deterrence strategy limited to prohibition and punishment is therefore bound to fail.

The MHAT V report[3] identifies several trends that further indicate a need for drug and alcohol prevention and counseling services during extended operations. The assessment reveals an overall rate of alcohol use during deployment of 8%.[3(p30)] During their second deployment, Soldiers report twice the rate of alcohol use, while noncommissioned officers report a 37% increase.[3(p47)] The use of inhalants was reported at 3.8% during deployment.[3(p30)] These rates of substance use support the conclusion that the number and length of deployments are contributing factors to an increase in substance use.

Current Problems and Forward Solutions

There are 2 obstacles to providing better support for Soldiers who are at-risk for using substances. The first is the lack of a policy for providing substance abuse treatment in theatre. The second is too few trained care providers to counsel at-risk Soldiers. Alcohol and drug use is a known risk factor for Soldiers suffering from any psychological and/or emotional difficulty. Policy recommendations and development are beyond the scope of this article. The MHAT V report addresses the lack of care providers by recommending that, prior to deployment, Soldiers with military occupational specialties (MOS) 68X* and 68W† receive training in substance abuse and other types of counseling.[3(p100)]

The concern about counselor training is also addressed in the OTSG/MEDCOM Policy Memo 07-026 dated 17 July 2007.[8] This memo focuses on the need for Mental Health Specialists to have work assignments that enable them to develop sufficient counseling skills to be proficient when they are deployed. The counseling training offered by the Alcohol and Drug Training Section (ADTS) is another resource to help Soldiers with either MOS 68X or MOS 68W gain proficiency in both individual and group counseling with little supervision.

Traditionally, the ADTS Individual and Group Counseling courses have provided training to MOS 68X Soldiers, civilian counselors, and other Soldiers/civilians with a background in providing healthcare. This includes medics and other Soldiers assigned to the Army Substance Abuse Program. This training, along with supervised work experience, provides a base of civilian and military counselors that have the necessary skills to effectively provide counseling to Soldiers. These basic counseling skills can be applied to provide counseling to Soldiers who are experiencing stress during deployment, or who may be drinking or using drugs to relieve PTSD or other symptoms of psychological distress. The AMEDD's goal of greater availability of counseling services in-theater is an effort aimed at directly decreasing the rates of alcohol and drug use during deployments.

Alcohol and Drug Training Courses

The ADTS at the Army Medical Department Center and School is comprised of skilled staff members who are committed to presenting relevant, quality training to substance abuse treatment providers. Based on the concept of life-long learning, the courses provided by the ADTS are essential for the Mental Health Specialist and the Healthcare Specialist. The courses are also a significant enhancement for credentialed providers at all levels of experience since students completing the courses receive continuing education units recognized by all major certification and licensing boards. ADTS courses currently offered:

The Individual Counseling Course (5H-F4/302-F4): This is a fast paced course that incorporates theory based learning and hands-on learning while training to improve the participant's counseling skills. This course provides a small group experience where students improve their skills through practice utilizing role play with a simulated patient.

The Group Counseling Course (5H-F5/302-F5): The most talked about of all the training provided by

*Mental Health Specialist
†Healthcare Specialist

ADTS, students can immediately use the skills they learn upon returning to their jobs. Throughout the first week, students get information and one-on-one time with an instructor to create a group design that will work in a deployed environment or at their home stations. The second week of the course provides a personal group experience for the participants. The experience is not a therapy group, however, participants do often report a therapeutic effect. Participants are given the opportunity for a glimpse into the power of group, both as a member and a leader. At the most recent group course, the excitement and reinvigoration of a civilian provider was evident as she indicated that she had been "stuck" with how to move forward with the PTSD group she was currently leading. There is no doubt she will implement all that she has learned to assist Warriors with their healing.

The Advanced Counseling Course (5H-F10/302/F10): The Advanced Counseling Course is a one-week residential course designed to provide military and civilian mental health technicians and other professionals with advanced training in substance abuse treatment. Special emphasis is given to topics frequently needed for license and certification renewal, including ethics, cultural diversity, family violence and HIV/AIDS. Experts from the field are invited as funds permit.

The Family Counseling Course (5H-F7/302-F7): The ADTS staff members are enthusiastic about the reinstatement of the Family Counseling Course. Due to lack of funding in the past, the April 2008 Family Course was the first to be conducted in several years. This year's Family Course provided essential tools to work with Warriors and their families who are under pressure due to PTSD and substance use. The students' response to the training was overwhelmingly favorable. Because of the numerous requests from the providers in the field, the ADTS staff is advocating for this course to be presented annually, rather than the current biennial schedule.

The Management Counseling Course (5H-F6): The Army Substance Abuse Program (ASAP) Management Course is limited to ASAP clinical directors or clinical supervisors who have more than 50% of their duties performing as a clinical director. The course is a one-week residential course designed to provide clinical directors with current treatment strategies, treatment developments, research data in the substance abuse arena, Joint Commission on Accreditation of Healthcare Organizations information, and updates from the Army Medical Command and other appropriate sources.

The Clinical Consultant Course (5H-F9): This course is designed primarily for physicians newly assigned as clinical consultants to the ASAP. The practical realities of the clinical consultant position, as well as technical tips and traps, are discussed at length. Experienced consultants also benefit because the course content varies from year to year.

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The Family Advocacy Staff Training Program

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The Family Advocacy Staff Training (FAST) Course was first developed in the mid 1980s by social work instructors and writers at the Behavioral Science Division of the Academy of Health Sciences, Army Medical Department Center and School (AMEDDC&S), Fort Sam Houston, Texas. The course was created in response to a request by the Department of the Army for orientation training for new Family Advocacy Program (FAP) staff in the family advocacy mission. The course was designed for both Active Army and civilian personnel, and included orientation training for professional, paraprofessional, and support personnel in 5 areas: direct services, administration, evaluation, prevention, and education. The course fielded by the Behavioral Science Division in 1985 was initially 3 weeks in length. Training was provided in the following areas:

- Administration and management (to include budget management) of the FAP
- Marketing of FAP
- Role of the Army Central Registry
- Development of primary and secondary prevention programs
- Investigation and assessment of child and spouse abuse reports
- Overview to the medical aspects of child and spouse abuse
- Roles and responsibilities of the members of the Family Advocacy Case Management Team
- Family Advocacy Case Management Team case determination process
- Treatment plan development

To successfully complete the course, students were required to prepare and present a 10-minute information briefing about their role in the family advocacy program to a senior field grade officer or civilian equivalent during the last week of the course.

In the late 1980s, the FAST course was changed from a 3-week Department of the Army Course to become the 2-week Department of Defense Family Advocacy Staff Training Course conducted by the AMEDDC&S. Students for this 2-week interservice course were from all branches of the military (Army, Air Force, Navy, and Marine Corps) with each service responsible for selecting their respective students to attend. The number of participants from each branch of service was determined by the size of their troop force, with the Army having the largest number of student slots, followed by the Air Force, Navy, and Marine Corps.

The newly designed 2-week course contained instruction that amplified the military's commitment to preventing spouse and child abuse by providing a range of essential services to strengthen Soldiers and families. The importance of providing victim safety and offender accountability continued to be a part of the training. The curriculum also maintained a focus on the primary purpose of the Family Advocacy Program, the prevention of spouse and child abuse and neglect. Breakout sessions for each student to meet with their service representative about their respective programs were included in the curriculum. Students also received instruction on the organization of the FAP, to include:

- Roles and responsibilities of the Case Review Committee
- Dynamics of child and spouse abuse
- Medical assessment of child abuse and spouse abuse
- Child sexual abuse
- Program implementation
- Legal issues
- Case investigation
- Records and resource management

The course continued to include a requirement that the students successfully complete a 10-minute information brief on their role in the FAP.

In the late 1990s, the Navy, Marine Corps, and Air Force optioned out of the 2-week course. The course again became the Department of the Army Family

Advocacy Staff Training Course. A decision was also made to drop the 10-minute briefing as a course requirement.

The 2-week course has continued to evolve to meet the needs of the field and to reflect the current research in the field of family violence. For example, blocks of instruction were added to address the issues of culture and the impact of substance abuse in family violence. Although the course is basic in orientation to the field of family violence, the change in course content is such that students who attended the course 10 years ago or more may be given a waiver to attend the course again to benefit from those changes.

Development of Distance Learning

Another pending change is the development of a distance learning component that will replace one week of the 2-week course. After completion of the distance learning element, students may apply to complete the one-week resident course. This distance learning component is being developed to conserve both the cost of training and the length of time course participants must be away from their jobs to attend training. Also, the development of distance learning training allows the inclusion of additional information that cannot be included in the 2-week course due to time constraints.

The first step in the development of the distance learning component was the determination as to which courses would be included in that training, and which courses should remain in the resident portion of the course. It was determined that blocks of instruction that are administrative in nature, and that training which is relevant to the problems of family advocacy could be accomplished in the distance learning component without compromising the quality of the training. For example, the block of instruction that addresses the topic of substance abuse and the family was included in distance learning training, not because it is not important in addressing the issues of child and intimate partner violence, but because it is not as pivotal in developing the accurate assessment and treatment of family violence. Training in the resident portion of the course will continue to be that instruction which is pivotal to the prevention and accurate assessment and investigation of the problems of child and spouse abuse.

It is anticipated that the distant learning component will be implemented no later than fiscal year 2010. Once it is fully implemented, costs savings should be substantial. The savings will allow more Army family advocacy professionals to take advantage of the training with no compromise in the quality of the course.

Advanced Training

The Family Advocacy Staff Training Course was designed to provide an overview of the issues of family violence by providing members of the multidisciplinary Case Review Committee (CRC) with an understanding of the role of each CRC member. To that end, a requirement was identified to provide skill-building courses for the members of the family advocacy program who have the primary responsibility for the prevention, education, and treatment aspects of the program. This recognition led to the development of 6 advanced courses to address the specific training needs of the family advocacy professional staff. With the exception of the Supervisors Course (3 days), all courses are 4½ days in length. In order to provide family advocacy clinicians and prevention and education providers with the most up-to-date training, the course content under the broader topic heading is changed each year to reflect the state-of-the-art training and most current research.

Child Abuse Family Advocacy Staff Training Course: Designed to assist family advocacy clinicians and educators in the development of skills to assess and treat the problems of child abuse. Specific training is provided on the prevention, identification, investigation, and treatment of child abuse. Blocks of instruction include training on child abuse risk assessment, family strengths and needs assessment, and intervention strategies for children and families.

Spouse Abuse Family Advocacy Staff Training Course: Provides advanced instruction on spouse abuse intervention and treatment issues. Blocks of instruction in this 4 ½ day course include an overview to the problems of spouse abuse, as well as training on spouse abuse risk assessment. Risk assessment is especially critical, as this assessment provides a foundation on which future treatment is based. For example, risk assessment informs the clinician if couples treatment is an option, or if the treatment should be provided in gender specific groups. Training

is also provided on various treatment options to address the problems caused by spouse abuse. Treatment approaches include treatment options for victims, offenders, and the children who witness violence.

The Prevention Family Advocacy Staff Training Course: Concentrates on prevention of abuse within the family by planning and implementing various programs for spouses, parents, and children. Law enforcement crime prevention as it relates to the prevention of child and spouse abuse is also included. Instruction addresses the topics of program planning and evaluation, budget management, and the development of prevention programs for spouses, parents, and children.

The Forensic Family Advocacy Staff Training Course: Provides advanced instruction on the acquisition of forensic interviewing skills of children so that detailed statements can be obtained of either their own abuse, or abuse that they have witnessed. A thorough statement with as much detailed information as possible is required whenever an allegation of child abuse or child sexual abuse is received. A research-based protocol that has been demonstrated to illicit free narrative from children about their experiences is used in this training. Small group instruction with multiple opportunities to practice the interview protocol is utilized as a key method of instruction. Training in court preparation is also included.

The Multivictim Family Advocacy Staff Training Course: Designed in recognition of the complexities in managing cases that include allegations of child sexual abuse that involve the potential of large victim pools. Frequently, allegations of this type of abuse occur in DoD sanctioned activities, which further complicates the assessment, investigation, and management of these cases. Blocks of training include instruction in the area of development of a victim matrix to assist in the identification of potential victims to be interviewed, legal issues associated with the investigation of these cases, and interview strategies for children, which includes information on memory and recall of events.

The Supervisory Family Advocacy Staff Training Course: Three days of training for civil service employees and social work officers designed to provide training in the development of supervisory skills. The course was developed in recognition of the need to provide training for individuals who are supervisors, but who have no prior experience or training in this mission. The course focuses on both clinical supervision and administrative supervisory responsibilities.

Training is also provided to military installations by mobile training teams (MTTs). They provide a 1½ day training session which focuses on team building for the CRCs and the installation clinical treatment team. The focus of the training is current research in the area of child abuse and intimate partner violence, as well as team building activities to assist the CRC in their group efforts.

Since the mission of the advanced training is to provide information on the most current research in the field of family violence, these courses are continuously updated to reflect the needs of the clinicians and prevention and education specialists serving our Soldiers and their Families. An example of such change is the inclusion of addiction information and its impact on the problems of family advocacy in one advanced course each year (either the spouse or child abuse course). This course is also made available to the alcohol and substance abuse clinical staff. The joint training was implemented to provide clinicians in both treatment areas with the best possible clinical strategies in the treatment of Army Families. Information on the impact of posttraumatic stress disorder is also included in this training.

SUMMARY

The Family Advocacy Staff Training Course has continued to evolve to provide the highest quality, research-based training to meet the needs of Army family advocacy professionals. The Behavioral Science Division is committed to ensuring that those charged with providing Family advocacy support receive the best training available in prevention, education, and treatment for our Soldiers and their Families.

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Battlemind Training System: "Armor for Your Mind"

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INTRODUCTION

From the time new recruits enter military service, they are drilled with the understanding that to accomplish the mission they must maintain and operate an essential weapon system. That essential weapon system is the trained and armed US Army Soldier. Historically, the institutional development of the US Army Soldier has included tough physical conditioning coupled with realistic technical and tactical training. This traditional approach to shaping new recruits has consistently produced a corps of tough, confident, flexible, and prepared Warriors capable of winning in combat and waging successful military operations. Battlemind training augments this skill set by building upon the Warrior's proven combat skills and mental fortitude—for truly we cannot send their bodies where we have not prepared their minds to go.

The term *Battlemind* was originally coined during the early 1990s by General Crosby Saint who, at the time, was the Commander of US Army Europe.[1] He recognized that there was a need to mentally prepare his troops to both deploy and then transition back to their home life successfully. Battlemind, as it is known today, came to fruition following the research findings of the Land Combat Study (2003-2004) spearheaded by COL Carl Castro and COL Charles Hoge.[2] These detailed deployment and subsequent redeployment data were collected and analyzed by their team at the Walter Reed Army Institute of Research (WRAIR). The needs identified by the analysis paved the way for the creation of the Army's premiere psychological resiliency program—Battlemind.

The Land Combat Study provided the statistical foundation from which Battlemind transformed from concept to application as a viable readiness enhancing tool for deployment cycle support training. The Battlemind Training System continues to develop as a program under a 3-pillar approach which includes deployment-related training, but has further evolved into institutional training.

Battlemind is now defined as a Warrior's inner strength to face fear, adversity, and hardship during tough times with confidence and resolution. It is the will to persevere and win. Battlemind training seeks to build upon a Warrior's proven combat skills, self-confidence, and mental toughness as critical aspects of their training. The Battlemind Training Office, located at the Army Medical Department (AMEDD) Center and School, Fort Sam Houston, Texas, continues to work in conjunction with WRAIR to develop research-based, relevant, psychological resiliency training that can be imparted in a language and manner to which Warriors can relate.

BATTLEMIND TRAINING OFFICE

In March 2007, the Combat Stress Actions Office was reorganized into the Battlemind Training Office, under the umbrella of the Soldier and Family Support Branch at the AMEDD Center & School. It is the platform from which all Battlemind and Combat and Operational Stress Control Training is developed and fielded.

The objectives of Battlemind training are to mentally prepare our Warriors for the rigors of combat and other military deployments; to assist our Warriors in their successful transition back home; to provide our Warriors with the skills to assist their Battle Buddy* to transition home; and, finally, to prepare our Warriors to deploy again in support of all types of military

*Defined as the person to whom a Soldier can turn in time of need, stress, and emotional highs and lows, who will not turn the Soldier away, no matter what. This person knows exactly what the Soldier is experiencing because he or she is currently going through a similar experience or has been through a similar experience and/or situation before.

operations, including additional combat tours. These objectives are accomplished via 3 distinct cycles of military life: Life-Cycle Training, Deployment-Cycle Training, and Soldier-Support Training. Each of these cycles builds from and complements the others. Life-Cycle Training strives to eliminate the stigma that surrounds the search for behavioral healthcare and to promote resilience throughout a Warrior's career. Deployment-Cycle Training provides Warriors with the skills necessary to thrive and adapt to the stressors of deployment, and then successfully transition from the extraordinary circumstances related to military deployments back to garrison and Family life. Finally, Soldier-Support Training addresses the unique needs and specific requirements of Warriors, their Families, and the military community at large.

Life-Cycle Training

Battlemind Life-Cycle Training institutionalizes Battlemind principles and concepts into the US Army training and education system. At the most basic level, Warriors are trained how to mentally prepare themselves for all types of contemporary military deployments while caring for their Battle Buddies. At the highest level, senior leaders will learn how to design organizational models which promote growth, reduce barriers to behavioral healthcare, and enhance total unit readiness for large troop elements. In other words, as our Warriors progress through their careers, they will continue to build their Battlemind skills in a way that is commensurate with their level of responsibility. It ensures our Warriors understand what is, and what is not, within their direct ability to control. There are currently 7 Battlemind Life-Cycle Training products in various stages of development. All institutionalized Battlemind training products will be fielded by the end of fiscal year 2009.

Basic Battlemind Training (BBT) is the building block for all life-cycle training. BBT will be trained at Basic Combat Training and One Station Unit Training programs of instruction. The tenets of BBT include trust in leaders, Battle Buddies, and promotes self-aid/buddy-aid skills which include peer intervention techniques to ensure physical and mental well-being. Warriors are taught to focus their thoughts, actions, and resiliency skills while never losing sight of their duty, values, and the Warrior Ethos, regardless of the situation they may find themselves.

Battlemind Warrior Resiliency (BWR) is the core competency training for all AMEDD enlisted and officer personnel. BWR is currently being trained in the AMEDD Enlisted Advanced Individual Training (AIT) and Officer Basic Officer Leadership Course (BOLC). This skills-based training emphasizes those skills learned in BBT; additionally, BWR teaches AMEDD personnel how to identify and assist Warriors who may be in need of behavioral health treatment. The principle message will be that psychological trauma derived from combat or operational deployments consists of predictable emotions that, when recognized and brought to light, are also treatable. BWR strives to eliminate perceived stigmas historically associated with Warriors seeking help for behavioral health problems.

Battlemind Warrior Resiliency–Transition targets those AMEDD enlisted and officer personnel who completed AIT and BOLC before the BBT and BWR were incorporated into training. This instruction includes elements of both BBT and BWR.

Battlemind Warrior Resiliency–Recertification ensures established BWR standards are maintained and validated to the required skill sets in the execution of unit-level resiliency programs. This module, akin to cardiopulmonary resuscitation recertification, will strive to remain a dynamic training program through the continued use of relevant updates based on further research findings.

Battlemind for Leaders (BFL) represents the continuation of Battlemind Life-Cycle Training resiliency training through the professional military education system. BFL builds upon the skills learned during BBT and begins to shift its focus to effective leadership techniques and its direct relationship to individual morale and the incidence of behavioral health issues in a unit. This training meets the requirements specific to junior leaders in the grade of E4(P) to E6 as well as that of company grade officers. Target delivery will be to noncommissioned officers (NCOs) attending the Warrior Leaders Course and the Basic Noncommissioned Officer Course, as well as to officers attending Basic Officer Leadership Course and the Captains' Career Course.

Battlemind for Leaders–Intermediate (BFL-I) builds upon BFL training and extends its focus to the implementation and management of organizational health policies at battalion and similar sized elements for staff positions and midgrade leaders. This training

not only addresses aspects of Warrior leadership, it also discusses effective techniques of mentoring junior leaders. Targeted delivery will be for NCOs attending Advanced Noncommissioned Officers Course, and to officers attending Intermediate Leader Education.

Battlemind Precommand and Senior Leaders (BSL) represents the culmination of Battlemind Life-Cycle Training that started with BFL and BFL-I. BSL will target the information and skills necessary to build, manage, and enforce umbrella organizational policies which promote unit readiness at brigade level and higher. It will also maintain a focus on resiliency issues unique for senior NCOs and senior officers in command positions. BSL will be taught during precommand and senior service courses, to include the Sergeants Major Academy and the War College.

Deployment-Cycle Training

Deployment-Cycle Training is part of the readiness initiative sponsored by the Army G-1 called the Deployment-Cycle Support Process. Battlemind training provides targeted education to be delivered at designated times throughout all 7 phases of deployment (training/preparation, mobilization, deployment, employment, redeployment, postdeployment, and reconstitution). Responsibility for the delivery of Deployment-Cycle Support training has been shared with the Chaplains Corps as directed by *Army Directive 2007-02*.[3] The combination of chaplains and behavioral health professionals significantly extends the capability for delivery of this training for deploying units. Deployment-Cycle training modules are designed to build upon existing Warrior strengths such as mental toughness, teamwork, and psychological resiliency as Warriors prepare to deploy and return from all types of military operations. These training modules were originally created and developed by WRAIR using data analyses from the Land Combat Study and subsequent Mental Health Advisory Team findings. The findings showed that Warriors wanted and needed training which provided them with coping skills and techniques that could be employed before, during, and after a difficult deployment rotation. The resulting training helps Warriors by providing them with concepts and tools designed to reduce the impact of stress of potentially traumatic events (PTE) prior to experiencing them in a deployment setting.

Pre-Deployment Battlemind Training

Pre-Deployment Battlemind Training (PDBT) is packaged into individual training for Warriors, leaders, helping-professionals, and military Spouses. Ideally, training is delivered in platoon-sized elements or working groups of no more than 40 students. Training for Spouses and Families is typically conducted by Family Readiness Groups or representatives at Army Community Service to similar sized groups of Family members. All modules prepare each of these groups for realities specific to their deployment experiences. In predeployment training for Warriors and leaders, they are prepared for a wide range of sensory, psychological, and emotional stimuli associated with military deployments. The leader training modules expand on the education by highlighting 10 tough facts for leaders, such as the expectation of and preparation for injuries and deaths of one's unit members, and to understand that deployments place a tremendous strain on Families. PDBT expounds on the 10 tough facts for leaders, and gives them some ways to help mitigate the predictable effects on both themselves and, especially, unit members and their Families.

Predeployment training for helping-professionals discusses 12 tough facts which include issues such as dealing with burnout, the delivery of bad news, and breaking down barriers to care. Finally, predeployment training for Spouses and Family members fills an extremely important, but sometimes overlooked, gap in preparedness. The training is conducted with the deploying Warriors and their respective Families. It provides a group setting opportunity to discuss what Warriors will experience on the battlefield, while also providing perspective to the Warriors as to what the Spouse and Family will experience while they are deployed. It emphasizes the importance of communication and understanding between Family members. Furthermore, it provides the Spouse and Family with home front expectations regarding the temporary change of roles within the household, having to wear "dual hats" as a parent, and when and where to seek help if needed while the Warrior Spouse is away.

Training During Deployment

During the deployment, Battlemind training focuses on managing the level of health and unit efficacy in the contemporary operating environment.[4] During a deployment, tragedy can take many forms, from a close call under hostile circumstances, unit casualties,

accidents, or even fratricide. Any of these incidents can shatter individual or unit effectiveness. Deployment-focused Battlemind training seeks to mitigate the effects of such events by reinforcing Warrior skills, self-aid/buddy-aid, battlefield ethics, and preparing Warriors to continue their missions. These skills are trained to Traumatic Event Management practitioners and reinforced during Battlemind Psychological Debriefings.

Traumatic Event Management (TEM) training plays an enormous role in helping Warriors and units bounce back. TEM offers information on combat and operational stress reaction, PTE, posttraumatic stress disorder, long-term stress reaction, and posttraumatic growth. TEM also teaches how to facilitate structured group discussions for Warriors who have experienced a significant incident in theater, and how to move on and grow from that experience. The TEM program was designed to provide a conceptual framework to provide the ability to flexibly apply supportive interventions in response to a PTE. Such interventions should be based on a thorough assessment of the impact and level of dysfunction that a specific or series of PTEs have caused organizations or individuals. The analysis of degradation resulting from PTE exposure results in a series of selective interventions intended to maintain unit cohesion and help units regain combat effectiveness as efficiently as possible. TEM was developed to include event- and time-driven formats which are flexible and focused on education, while allowing participants to explore predictable reactions to extraordinary stimuli.

Battlemind Psychological Debriefing (BPD) was developed by WRAIR after extensive research with military populations.[6] While there are several different kinds of debriefing models, BPD focuses on the unique aspects of what Warriors must deal with on the modern battlefield. BPD training is provided to Behavioral Health and Unit Ministry assets. When necessary, the BPD-trained TEM practitioner can lead or facilitate a debriefing with a group who has just experienced a PTE while serving in the contemporary operating environment. The BPD format attempts to help Warriors make sense of PTEs, and restore a sense of duty and honor to the participants so that they can continue with their mission. BPD is different from existing civilian debriefing models in that the Soldier in a combat zone may be required to endure similar traumatic events on multiple occasions, simply because of the nature of the work. That stands in stark contrast to the normal civilian experience—the affected individual will likely never be exposed to a similar PTE again, and the odds of repeated exposures are infinitesimally small. Therefore, the civilian debriefing model has as its goal assistance and preparation of the individual to recover and continue with the rest of his or her normal life.

Postdeployment Battlemind Training

Postdeployment Battlemind training closes the loop on training for Warriors and their Families in regards to the deployment cycle. Part of the findings from the Land Combat Study include a requirement for training how to transition combat skills to home skills. Warriors have difficulty reintegrating into their home life and with their Families on predictable timelines following a deployment.

Battlemind I Training (Postdeployment Health Assessment) is presented to Warriors who are redeploying, or who have recently returned from a deployment. This module discusses normal homecoming expectations and how to successfully transition from the combat zone to the "home zone." This one-hour block of instruction provides self-awareness training to Warriors, adaptation skills, and education on finding behavioral health resources. Additionally, it discusses how to modify desirable combat skills which helped the Warrior to survive the deployment into skills that will be useful when back with Family and friends.

Battlemind II Training (Postdeployment Health Reassessment) is complementary training to the Battlemind I module presented at the 3- to 6-month mark following a deployment. It discusses the ongoing transition home and how to work through problems which commonly arise among combat veterans. The training reinforces the self-aid/buddy-aid concept and attempts to dispel common myths associated with seeking behavioral health assistance.

Battlemind Training for Spouses and Families is presented to Warriors and their Families in much the same manner as the predeployment version. This block reviews matters discussed prior to deployment, and helps Families start a dialogue regarding how things have changed since the Warrior was first deployed.

The major theme of this training centers on the Warrior and Spouse becoming a team again. During a Warrior's deployment, the Family unit may begin to rely on external support, and individuals may become personally independent. The responsibility of the Warrior to transition his or her combat skills is discussed, but that responsibility is paired with the spousal responsibility to transition the home front deployment skills as well.

Soldier-Support Training

Soldier-Support Training (SST) captures the unique populations and subjects that Life-Cycle and Deployment-Cycle modules do not. SST will provide Battlemind training to extended support systems, including specialized populations such as National Guard and Reserve Component specific issues, military Families, and network health providers.

Chaplain Train the Trainer: The goal of the course is to teach chaplains and chaplain assistants how to return to their installations and train remaining chaplains and behavioral health assets in the effective presentation of Deployment Cycle Support Battlemind Training. Modules mandated by the Army G-1 include: Predeployment Battlemind training for Leaders and Warriors, Battlemind I (Postdeployment Health Assessment training), Battlemind II (Postdeployment Health Reassessment Training), Traumatic Event Management training, Battlemind Psychological Debriefing training, and Pre/Postdeployment modules for Spouses and Families.

The Combat and Operational Stress Control (COSC) Course is the premier platform of deployment centric prevention training for behavioral health and unit ministry personnel. The course offers 5 days of didactic education and practical exercises on the latest COSC doctrine and battlefield updates. In addition to doctrinal training, students also receive briefings on related areas including analysis of the most recent Mental Health Assessment Team data, mild traumatic brain injury/concussion awareness, the Army Center for Enhanced Performance* Education Model, Battlefield Ethics, Sexual Assault Prevention In-Theater and briefings from the Navy, Air Force, and Marine Corps COSC professionals. Priority of attendance for this course goes to personnel preparing to deploy overseas in support of Operations Iraqi Freedom and Enduring Freedom. Priority attendees also include Air Force behavioral health personnel who have been tasked to deploy in lieu of Army personnel to support Army missions. Advanced modules of the COSC Course are in development and will have more practical exercises and hands-on training which focus on specific key COSC prevention and intervention concepts.

Warriors in Transition (WT) are those Warriors who are assigned to a Warrior Transition Unit (WTU). These Warriors receive treatment and rehabilitation for injuries sustained in the combat theater. The Battlemind Training Office (BTO) has developed training for WTU staff during the WTU Residence Course to include training in Suicide Awareness and Battlemind Resiliency Training. The Spouses, Families, and friends who care for WTs who are recovering from both physical and psychological trauma are known as WT Caregivers. BTO is in the process of developing training modules, videos, and a counseling program that focuses on the unique needs of WT Caregivers.

Website, Interactive Videos, and Marketing

As with anything in this world, information is essential in making sound decisions and keeping ourselves aware of our surroundings. The marketing of Battlemind is a crucial component in raising the awareness of our Warriors, commanders, Families, and other organizations about the products and programs we have available. The BTO has and continues to promote its programs in several different ways in order to reach as many people as possible. Recently, the BTO launched an internet portal which has become the Army's official Battlemind website (http://www.battlemind.army.mil). It will become a major conduit for the BTO to dispense information and training, and will be a resource for Warriors, Families, commanders, and behavioral health providers. Marketing of the Battlemind logo and its tenets have taken the BTO from booths at several conferences to the training of Air Force behavioral health providers and Canadian, El Salvadoran, and Slovenian military personnel.

*The Center for Enhanced Performance is a department of the US Military Academy Preparatory School, West Point, New York. Information is available at http://www.usma.edu/USMAPS/pages/academics/cep_home.htm.

Education is the primary leverage we have in the development of awareness and an understanding of the issues that challenge the wounded Warrior. Technology as a fundamental modality of education today is effective and readily available. The AMEDD Battlemind Training Office believes that there is significant value in creating Virtual Experience Immersive Learning Simulations® that will allow both wounded Warriors and those involved/invested in their recovery to practice dealing with issues in computer-based and/or web-based experiences. Such simulations allow people to explore and understand issues and challenges in a way that helps them prepare for successfully dealing with those issues and challenges when they face them in real life.

The BTO in concert with AMEDD Television are currently working on several video projects that will be used to educate Warriors and Family members to include Suicide Awareness, Posttraumatic Stress Disorder, and Seeking Behavioral Health Care / Reducing Stigma.

CONCLUSION

Although still in its infancy, the Battlemind Training Office has become the largest training branch in the Soldier and Family Support Branch at the AMEDDC&S. The diverse and important missions of BTO have become a focal point within the AMEDD and at senior Army command levels. Campaigns during Operations Iraqi Freedom and Enduring Freedom have shown us that we must remain flexible to be able to meet mission objectives. BTO strives to be proactive, flexible, and as forward thinking as possible. Remaining focused on the Warrior and their Family needs remains our objective. Preparing Warriors, leaders, and their Families for the operational tempo of our current Army is of crucial importance.

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The Army Master of Social Work Program

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Introduction

For nearly a century, civilian universities have assumed a major role in recruiting, preparing, and equipping behavioral science professionals to serve in the various uniformed services. This is especially true as it relates to Army social workers, who have played an integral role in the Army's attempt to provide comprehensive medical healthcare to Soldiers and military Family members since the birth of Army Social Work in November 1943.[1] Shortly after the creation of the Army Social Work military occupational specialty, Fort Sam Houston developed a subprofessional training program that would help mold and prepare civilian educated social workers for the difficult mission that they had chosen to pursue.[2] From 1918, the year in which Smith College opened the doors of the Smith Psychiatric Training Program with the expressed purpose of educating civilians to work as social workers in military communities, until 2008, civilian universities have had a clear and definite role in the development of military social workers. The civilian universities educate them, and the Army refines them via military specific training. However, on February 2, 2008, the partnership between Fayetteville State University (FSU) and the Army Medical Department (AMEDD) changed this with the development of the Army-Fayetteville State University Master of Social Work (MSW) Program.

This article provides a historical glimpse at the circumstances that led to the development of a master of social work program at Fort Sam Houston. In addition, the article provides an overview of the admission standards, Council on Social Work Education considerations, and the steps that the Army Medical Department Center & School (AMEDDC&S) and Fayetteville State University take to ensure consistency through close collaboration and partnership in the creation of the program.

Historical Perspective

In November 2006, The Army Surgeon General, in response to a recognized shortage of social work officers, approved a proposal for the AMEDDC&S to establish a master of social work program to educate and train military social workers to meet the behavioral health needs of Soldiers and their Families. The plan for the Army to develop a graduate-level education program was originally presented to The Surgeon General by Colonel Yvonne Tucker-Harris, the Social Work Consultant to The Surgeon General.[3] The War on Terror, multiple deployments, increases in the attrition of company grade social work officers, and licensure requirements were adversely affecting the social work inventory. Moreover, it has become increasingly difficult to recruit and retain competent and committed Army social workers. Thus, it was clear to Army leadership that more social workers were needed, and, based upon the reality that social workers in the Army were operating at 75% strength, it was apparent that the Army could no longer maintain the status quo if it intends to meet the mental health needs of the force in the present and years to come.

Civilian colleges and universities have been teaching classes on social work related issues since 1898, and offering graduate educations since 1945.[4] The Army has been relying upon civilian universities to develop social workers who may be interested in pursuing a career in the military since 1918.[5] As such, one might question why, after half a century of reliance upon civilian accredited universities to produce Army social workers, would the Army seek to develop a graduate social work degree producing program?

Even though civilian universities are the sole proprietor of accreditations that enable them to offer graduate and undergraduate social work degrees, there remains a dearth of information in social work curricula about practicing social work in a military environment.[6] As a result, even though graduate-level trained social workers possess general knowledge about the values, practices, and skills of social work, most of them know little to nothing about practicing social work in a military environment. Simmons and Vaughn[6] revealed that the majority of military social workers found that a large percentage of their graduate education was irrelevant, and that their best training was received on the job. Therefore, even though new

Army social workers had to endure the arduous educational process that graduate social work programs offered, novice Army social workers entered the Army with a significant degree of ignorance about how to apply their social work knowledge and skills in a military environment. In fact, it was the recognition of an absence of knowledge about how to practice social work as a uniformed officer in a military environment that compelled the AMEDD to establish the Army Psychiatric Social Work Training Program at Fort Sam Houston, Texas, in 1945.[2]

Another contributing factor to the development of the Army-FSU MSW Program was the Army's inability to access new social work graduates due to independent practitioner licensing requirements. Since October 1998, in compliance with federal law,[7] the Army Medical Command has required that all active duty, reservist, individual mobilization augmentee, and civil service social workers must possess a current, valid, unrestricted (independent) professional license to practice as part of the Army Medical Department. Over the years, this policy has impacted the availability of social workers that were eligible to enter and deploy as independently practicing healthcare providers. In most states, a graduate level educated social worker must complete a minimum of 2 years postgraduate supervision under a licensed clinical social worker before he or she will become eligible to take the independent practitioner exam.[8] As a result, civilians attending traditional social work programs are not eligible to enter the Army upon graduation because of the statutory requirement for Army social workers to have independent practitioner status. Therefore, the Army has been limited in its ability to recruit those new social workers who may be inclined to pursue a career in the military. Instead, the Army has sought to attract social workers with independent practitioner status, many of whom are already established in a stable professional career, and therefore less likely to consider a career in the military.

A final contributing factor for the establishment of an Army MSW Program is related to the stress and uniqueness of serving as an Army social worker. The rigor of serving as a social worker with the military force is definitely taking a toll on the social work force, reflected by an estimated 10% attrition each year in the number of social workers on active duty. Although new social workers are recruited each year, it is almost impossible to keep pace with the attrition rate. This factor has highlighted the importance of recruiting social workers who are not only knowledgeable, but who are also committed to serving as military social workers. This proved to be a major factor that inspired the focus of the Army-Fayetteville State University MSW Program. COL Joseph Pecko, Director of the Army-FSU MSW Program, pointed out that the program is designed to address the retention problem by recruiting current military personnel who understand the Army lifestyle and have an appreciation for what their commitment entails.[9]

Program Organization and Admission Standards

The Army MSW Program is affiliated with FSU as an offsite program. Fayetteville State University is accredited by the Council on Social Work Education to provide graduate social work education. Further, the curriculum offered by the AMEDDC&S to students that attend the Army-FSU MSW Program is identical to the curriculum that the students receive on the FSU main campus. The curriculum is designed to provide graduate social work education to individuals with an undergraduate education in social work and other liberal arts related areas.

The Army MSW Program was designed to serve as a force multiplier for the depleted social work inventory by educating and training 15 to 20 Army social workers per year. The program meets the Council of Social Work Education curriculum standards for an offsite program of Fayetteville State University. The students selected to attend the program must have a liberal arts undergraduate education, have demonstrated an ability to perform academically at the graduate level, and express a strong desire to serve as an Army social worker. Current active duty Soldiers have been targeted as the primary source for students in the Army-FSU MSW Program.

The first cohort attending the Army-FSU MSW Program is being exposed to an intense, clinically-focused social work curriculum that will help students understand the history, principles, practices, and skills they will require to successfully perform as social workers in a military environment. In addition, the students receive a heavy dose of social work ethics, human behavior in the social environment, policy practice, a variety of direct clinical practice courses, as well as a number of military specific electives. The objective of this graduate program is to thoroughly prepare, in a military environment, future social workers in accordance with the standards of the

Council of Social Work Education so that each graduate will be well versed in how to apply, within the military, the knowledge, skills, and values they have acquired during their graduate program.

It would typically require a civilian program 2 years to provide the type of educational program that a student in the AMEDDC&S program will be completing in 12 to 13 months. Once these students graduate, they will go on to a select military installation to complete a 2-year internship under the direct supervision of a licensed clinical social worker. This will enable graduates of the Army MSW Program to serve as social work officers in half the time it would have taken them had they attended a traditional civilian education program. In addition, graduates of the Army MSW Program will have a direct impact on the social work inventory upon graduation, and will immediately begin working with Soldiers and Family members who may be affected by the requirements of the Global War on Terror. However, graduates of the program will not be eligible to deploy until after they have received their license as independent practitioners. This will occur after each graduate of the program completes the postgraduate internship and passes the independent practitioner licensing examination.

Promoting Continuity Through Partnership

In February 2008, FSU and AMEDDC&S developed an educational partnership that marked a change in the way social work education would occur for Army social workers. However, an enormous amount of collaboration occurs behind the scene to ensure that the integrity of the curriculum remains intact. Key members from the FSU Department of Social Work and the AMEDDC&S teaching faculty remain in constant contact via telephone conference calls, site visits, and video conference calls. The AMEDDC&S teaching faculty have joint appointments as faculty at FSU and at the AMEDDC&S. All curriculum and admission decisions are approved by the program director at FSU and the director at AMEDDC&S. The teaching faculty at the AMEDDC&S attend monthly faculty meetings with the other FSU faculty via videoteleconferences, and they are also members of other faculty committees at FSU. Dr Terri Moore-Brown, Director of the FSU Department of Social Work, described the partnership as a win-win situation.[9]

The strength of any partnership is contingent upon the degree to which both parties benefit from the relationship. In this partnership, FSU benefits through the opportunity to educate future Army social workers who, in turn, will serve throughout the world. In addition, FSU will also have the opportunity to serve as coprincipal investigators in an array of research opportunities that will take place at the AMEDDC&S. The AMEDDC&S benefits from the opportunity to work with a quality university that has a curriculum that is consistent with the needs of the military, which enables the Army to expeditiously offer an accredited graduate education to qualified Soldiers who desire to become social work officers.

Conclusion

Since 1918, the Army has relied upon civilian universities to educate and prepare social workers to serve in the military. Throughout the years, this arrangement has been fraught with complications for which the military has compensated by establishing its own military specific on-the-job training. The War on Terror, with a large percentage of Soldiers and Family members suffering, has caused the Army to rethink this arrangement. The Surgeon General of the Army called for more mental health providers, and the social work consultant recognized that it was a time for a change. The Army needed more competent and committed social workers now, and the Army's reliance upon civilian universities had proved to be insufficient in providing the number of social workers that was needed. The Army-FSU MSW Program represents the change that was required to equip the Army with 15 to 20 new social workers each year.

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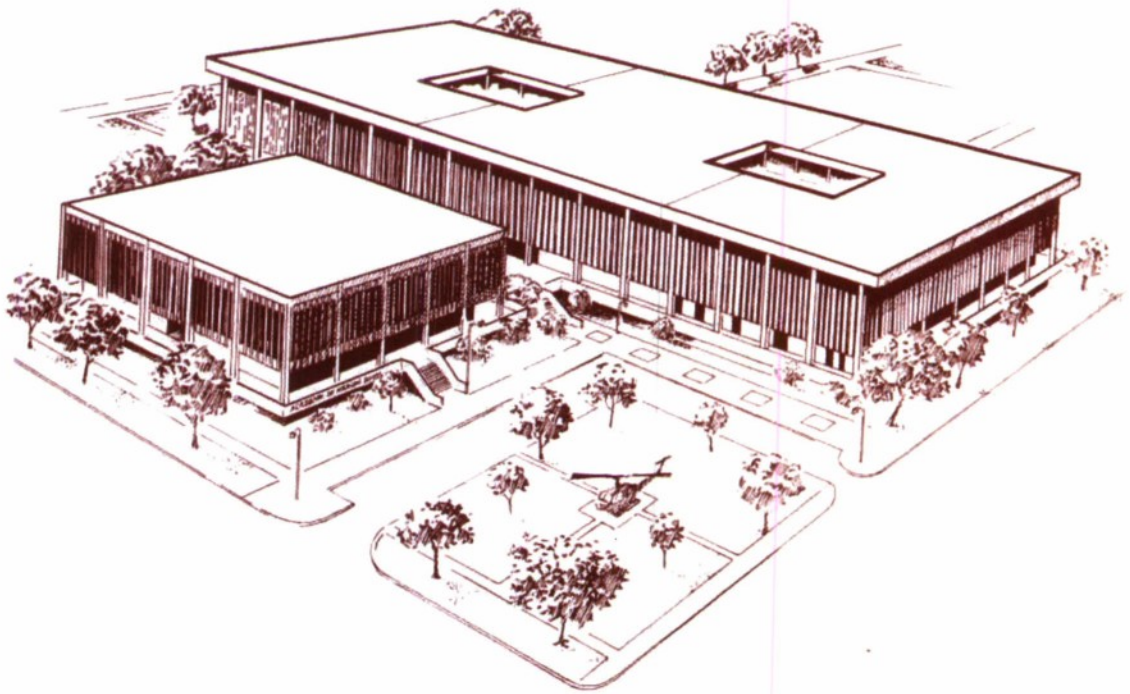

The US Army Medical Department Center and School, Fort Sam Houston, Texas

THE US ARMY MEDICAL DEPARTMENT REGIMENT

The US Army Medical Department was formed on 27 July, 1775, when the Continental Congress authorized a Medical Service for an army of 20,000 men. It created the Hospital Department and named Dr Benjamin Church of Boston as Director General and Chief Physician. On 14 April, 1818 the Congress passed an Act which reorganized the staff departments of the Army. The Act provided for a Medical Department to be headed by a Surgeon General. Dr Joseph Lovell, appointed Surgeon General of the United States Army in April 1818, was the first to hold this position in the new organization. The passage of this law marks the beginning of the modern Medical Department of the United States Army.

Throughout its early history, the size and mission of the US Army Medical Department would wax and wane in response to military events around the world. There was, however, no formal regimental organization until World War I. Then, in the late 1950s, the brigade replaced the regiment as a tactical unit. In the reorganization that followed, some Army units lost their identity, their lineage, their history. This loss did not go unnoticed. The US Army Regimental System was created in 1981 to provide soldiers with continuous identification with a single regiment. Department of the Army Regulation 600-82, The US Army Regimental System, states the mission of the regiment is to enhance combat effectiveness through a framework that provides the opportunity for affiliation, develops loyalty and commitment, fosters a sense of belonging, improves unit esprit, and institutionalizes the war-fighting ethos.

The US Army Medical Department Regiment was activated on 28 July, 1986, during ceremonies at Fort Sam Houston in San Antonio, Texas, the "Home of Army Medicine." Lieutenant General Quinn H. Becker, the US Army Surgeon General and AMEDD Regimental Commander, was the reviewing officer. He was joined by general officers of the US Army Reserves and the Army National Guard, representing the significant contributions and manpower of the reserve forces in the Total Army concept.

The Regimental web site (http://ameddregiment.amedd.army.mil/default.asp) is designed to provide you with useful information about the US Army Medical Department (AMEDD) Regiment. Through the web site, you can learn the history of the AMEDD Regiment, the symbolism behind our heraldic items, how to wear the Regimental Distinctive insignia, and various programs available to you and your unit.

The Office of the AMEDD Regiment is located in Aabel Hall, Building 2840, on Fort Sam Houston, Texas. The Regimental staff can provide further information pertaining to the history of the Army Medical Department and the AMEDD Regiment, and assist with any of the services described in the web page.

For additional information please contact the Army Medical Department Regimental Office at the following address:

Commander
US Army Medical Department Regiment
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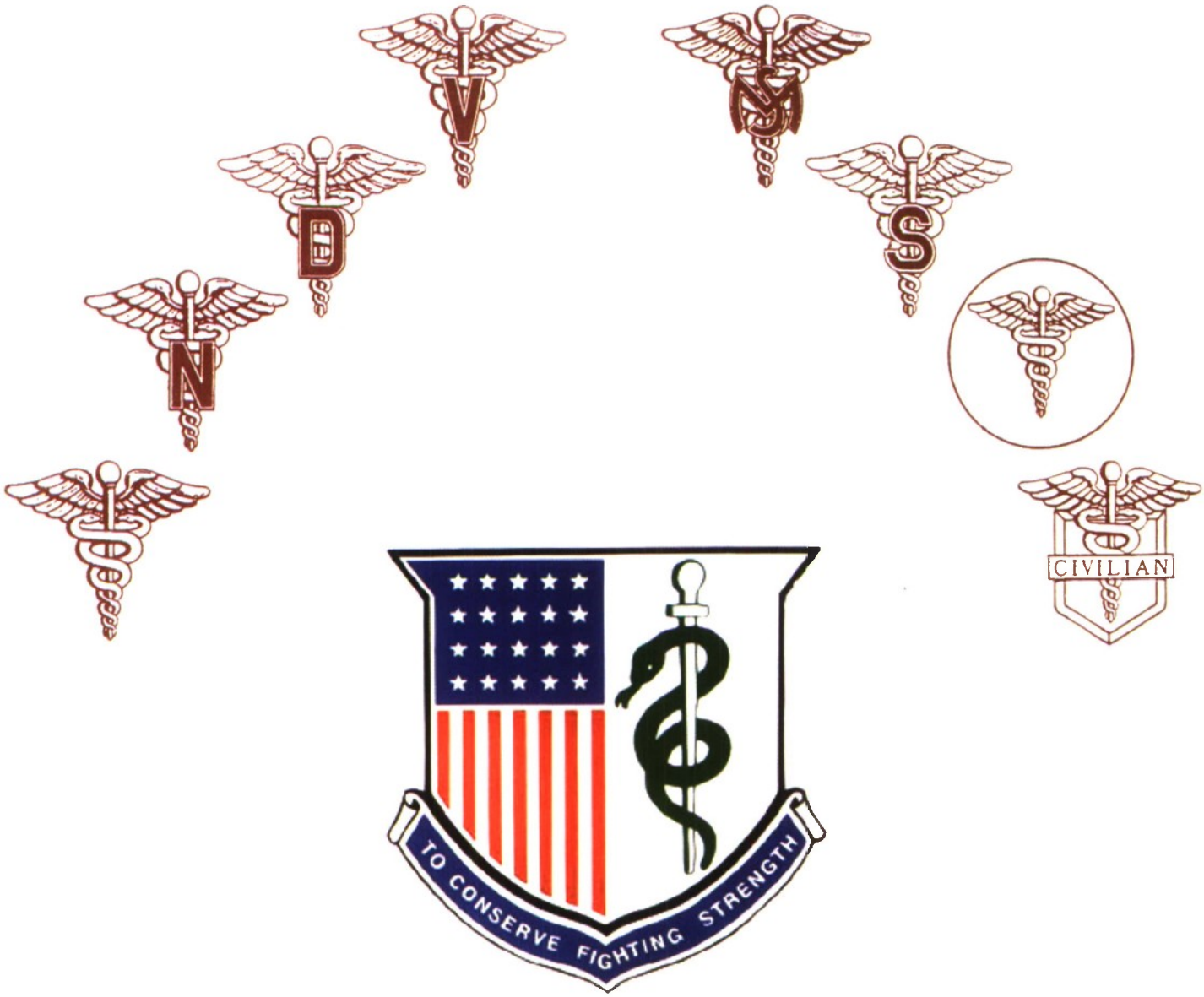

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